

research
in practice
for adults

Outcomes

Information and Resources

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Introduction

This is a working document. Resources may be added and information updated. Please use this as a starting point. It contains a variety of information, evidence, resources and contacts around the theme of outcomes-focused adult social care. Additional resources may be found on the **ripfa** website under Resource Bank.

This pack has been produced following requests from several Partner agencies for one-to-one support. It is intended to provide practice examples, useful tools and signposts to agencies developing outcomes-focused support in adult social care.

If using any of the resources contained in this pack, please refer to the original creator of that resource for permission to use their work. By listing resources here, **research in practice for adults** is in no way advocating their use, promoting their worth or giving permission for them to be used. Please contact the original creators of these resources for their advice on implementation of any of these documents. Links and contact details are provided where possible.

Definitions

Input = Provision to achieve outcome
(E.g. staff, care, equipment)

Output = End point produced by process/activity
(E.g. Number of people supported to stay at home)

Measure = How the indicator is achieved
(E.g. How much did we do? How well did we do it? Is anyone better off?)

Indicator = How that impact can be seen or assessed

Outcome = Impact/result of services on a person or population
(i.e. the person receiving support)

Very simply, the above summarises what is meant by these terms in the following pages. These descriptions are based on various documents, presentations and explanations used in policy, research and practice guides.

Background and Policy

It is firmly established that setting a vision is essential to building a holistic and outcomes-based service. Both the Department of Health (DH) and Commission for Social Care Inspection (CSCI) in their discussions on the Health and Social Care Outcomes and Accountability Framework talk of a policy direction towards locally-led services being outcomes-focused and measured. Several national policies are fundamentally linked to an outcomes focus, not least the personalisation of services and integrated health and social care. When developing an outcomes strategy, one of the key emphases from pilots and research is that an awareness of other strategic agendas, existing projects and initiatives and cross-boundary working is essential to achievement.

As a result of emerging strategies, new frameworks are needed to support them. This includes the Outcomes and Accountability Framework for Health and Social Care. The drive behind this is performance management. However, emphasis has shifted towards public views and local priorities. Following the 2007 Comprehensive Spending Review, a new performance management framework was outlined. This established national, outcomes-focused indicators linked to each Public Service Agreement. This specifically targets performance of local authorities in relation to achieving government defined outcomes.

The narrative document *Delivering health and well-being in partnership: the crucial role of the new local performance framework* from Communities and Local Government and the Department of Health provides a useful summary of the various elements that contribute to the new performance framework established under the Local Government and Public Involvement in Health Act 2007. The Joint Strategic Needs Assessments and Local Area Agreements (LAAs), designed to recognise and prioritise health and well-being needs of local populations are focused on outcomes. For the LAA, local targets are to be agreed for 35 indicators from the 198 in the National Indicator Set (NIS), together with any local targets that are agreed between the partners.

At the same time the NHS operating framework for 2008-09 emphasises partnership working in order to deliver outcomes: 'the aim is that the performance regime within which any local delivery agency operates is coherent and supports improved local delivery while incentivising partnership working as a means to achieve this'.

Alignment between the local authorities and the NHS will involve:

- common outcomes and measures for tracking progress against them
- LAAs and PCT operational plans which have equal standing
- co-ordinated and shared assessments, by Inspectorate, regulators and SHAs
- co-ordinated support for improvement
- co-ordinated intervention where necessary.

From April 2009 Comprehensive Area Assessment (CAA) will replace Comprehensive Performance Assessment (CPA) and the social care star ratings. The focus will be on outcomes and there will be four key elements: risk assessment; use of resources score; direction of travel score; and local performance data set against the national indicators. As part of the National Improvement and Efficiency Strategy, Regional Improvement and Efficiency Partnerships (REIPs) will have a key role in supporting the delivery of health and social care outcomes. Each Government Office will work with the Local Strategic Partnerships (LSPs) to ensure that the local partnerships are robust and engaged in the LAA process. The DH social care presence is to be strengthened in the regional government offices. The document includes an essential timeline detailing the three phases of implementation to April 2009.

Our Health, Our Care, Our Say (2006) identifies seven outcomes around the concept of well-being. These are nationally focused outcomes. The Department of Health's *Modernising Adult Social Care* (2007) and *Putting People First* (2008) follows a strong commitment to outcomes-focused services, as does *Strong and Prosperous Communities* which outlines the new local performance framework, based on an outcomes approach with the aim of improving performance, accountability and consistency.

The National Service Framework for Older People has supported an outcomes-focused approach to service provision. However, the single assessment process has proved

problematic in developing outcomes-based assessments and care plans. Some Local Authorities have begun to address this issue by developing their own in-house assessment systems and paperwork.

Outcome-based Accountability

CSCI and others recognise that outcomes are not mutually exclusive. There will be a variety of outcomes using various indicators to demonstrate success or need for improvement. This makes measurement complicated and means that determining outcomes and how these will be measured is crucially important.

Outcomes-based accountability is based on work carried out in the USA. It has also been trialled to some extent in Childrens' Services here in the UK. The Improvement and Development Agency (I&DeA) have produced some evidence on this, including *'improving service delivery – introducing outcomes-based accountability'* (see page. 14).

CSIP (Care Services Improvement Partnership) highlights two areas of accountability in terms of Outcomes. Firstly **Population Accountability**, which refers to whole populations, such as counties and cities, and **Performance Accountability**, smaller populations, for example individual programmes or services. This differentiates the targets that may be needed in establishing where outcomes are focused. In determining outcomes for individuals, communities and whole populations, they provide sets of accountability questions (*see Appendix 1*). These questions may be useful in establishing a vision or statement for outcomes-based services.

Outcome-based Indicators

Within the Department of Health's consultation on the Health & Social Care Outcomes and Accountability Framework 2008-2011, it suggests six principles for assessing the suitability of indicators for the framework.

- 1 Data need to be available at PCT and/or Local Authority level
- 2 Data need to be available regularly
- 3 Data need to be statistically robust
- 4 It should be an appropriate measure of the framework outcomes
- 5 It should avoid perverse incentives or unintended consequences
- 6 It should promote improvement

Whilst very generic, these can prove useful for establishing the appropriateness of an indicator for hard outcomes.

As suggested above, individual indicators will not fit neatly into categories, so need to be established through support plans, using eligibility criteria and practice guidance. These are often referred to as soft outcomes.

Outcomes for Adult Services

The White Paper *Our Health, Our Care, Our Say* established 7 outcomes for Adults.

- | | |
|----------------------------------|--|
| 1 Health & Emotional Well-being | 5 Freedom from discrimination & harassment |
| 2 Quality of life | 6 Economic well-being |
| 3 Making a positive contribution | 7 Personal dignity and respect |
| 4 Exercising choice and control | |

The Social Policy Research Unit (SPRU) identified ten outcomes valued by adult service users. These are;

- | | |
|--|--|
| 1 Maintaining Independence | 6 Keeping active and alert |
| 2 Keeping clean and comfortable | 7 Living healthier and longer lives |
| 3 Enjoying a clean and orderly environment | 8 Maintaining an adequate income |
| 4 Being safe | 9 Having opportunities to contribute to family and community |
| 5 Sustaining social contact and company | 10 Feeling valued |

Research suggests that ‘the ordinary things in life’ are valued most by service users. Generally, service users are not concerned with who funds what or how that service is delivered. What matters to them is that they make their own choices, that they are safe and well and that they are treated with respect. These outcomes reflect what most people would expect in their life, and this is what users want from social care. From these 10 outcomes, 3 types of outcomes are identified. These are Change, Maintenance and Prevention and Service Process. The following are examples of what each of these might look like.

Change

Feeling better, no longer needing a walking frame, managing anger

Maintenance or Prevention

Wearing clean clothes, having a working smoke alarm, taking necessary medication

Service Process

Information in an accessible format, face-to-face contact at an appropriate time

It has been established that Change Outcomes are often easier to identify and measure than other outcomes. This means that agencies need to establish how they will measure outcomes and what their indicators will be in measuring effectiveness. Research does in fact suggest that Process Outcomes are important to individuals in many ways, so measures showing that a service is delivered on time and in an accessible way are also important.

Local Authorities need to be aware that there are varying types of outcomes; that nationally established outcomes that can be measured and quantified may differ from those at a local level or individual level. These national measures need to be translated into local measures. Measures should be no less valued for an individual than for a National Indicator Set and should in theory be complementary. The purpose of being outcomes-focused is that the individual should be involved and central to establishing their own outcomes, measures and indicators.

Outcome-based assessment and care planning will of course be central to achieving this. It is worth considering the following steps;

Set the outcomes the individual wishes to achieve

- Training and support will be needed to enable staff to establish individual outcomes
- Paperwork will also need to follow the approach
- Refer to the research outlined in this document for guidance
- Communication, in particular listening are emphasised as crucial at this stage

Set the outcomes within context e.g. FACS

- Eligibility for services still stands
- Work within policy contexts within the locality

Devise a plan to achieve the outcomes

- What do they hope to achieve?
- Who needs to be involved?
- What does the individual need to do?
- What input is required from social care?
- What input is required from other parties?
- Clarity is crucial
- A plan does not have to be written, but may need to be using pictures, video, aural etc. It needs to be an individual plan
- See the research section for issues relating to SAP etc.

Implement the plan

- Be realistic
- Work with provider services to encourage any new ways of working
- Engaging with new agencies, individuals and services may be needed (e.g. building links with a voluntary scheme or housing department)

Review

- Crucial to outcomes-based approaches
- Set a time scale for review (e.g. week/month) and measure against the outcome – i.e. how much has been achieved for each outcome for that individual

Revise

- Update any ongoing outcomes, develop the plan
- Establish any new outcomes
- Measure achievements and ongoing outcomes against original plans

Resources within this document can be used to support and inform each of these stages.

Messages from Research

1 **Progress and problems in developing outcomes-focused social care services for older people in England** (2008) Caroline Glendinning, Susan Clarke, Phillippa Hare, Jane Maddison and Liz Newbronner, *Health and Social Care in the Community*, Volume 16, No 1, 54-63

- Varied use of the word 'outcomes' continues
- Practical changes are required in planning, commissioning and delivering services
- Changes are needed at a practice level to operate an outcomes-focused service
- Outcomes-focused assessment is incompatible with the Single Assessment Process which focuses on needs. This can be overcome;
 - Incorporate outcomes into care planning – e.g. have an 'outcomes checklist' including change and maintenance outcomes
- Reablement services have had success with implementing service commissioning for change outcomes
- In order to commission for maintenance outcomes, changes need to occur within home care services – there needs to be a refocus on quality of life rather than physical need. (This concerns a whole system change). Flexibility is key
- Three Key Factors to facilitate an outcomes-approach
 - National Policies (NSF, PIs and inspection, Reablement and intermediate care)
 - Local Vision (leadership and investment in change management, staff training, clear communication)
 - Partnerships (formal joint working, relationships, trust, shared values, shared understanding of terminology)

2 **Developing outcome-focused practice: examining the process** (2004) Nicholas, E. and Qureshi, H., *Research, Policy and Planning*, Volume 22, Issue 3, pp. 1-14

- Tools and training are important for getting outcomes into practice, but there is a lot more to enable transformation
- This is a long term process
- Roles, cultures and systems all need to change as well as individual practice
- These pilot projects showed benefits to service users suggesting a value to outcomes
- Start small, work with those who are enthusiastic but also engage all stakeholders
- Link to other policies and initiative will make it appear less demanding and offer a structure
- The cultural change may be difficult, engage managers, practitioners, service users and carers in the change process to ensure they understand what 'outcomes-focused' means
- Engaging practitioners in developing practice will encourage ownership which will enable the process and motivate

- 3 **Outcomes for disabled service users** (2005) Harris, J., Foster, M., Jackson, K. and Morgan, H., Social Policy Research Unit, University of York.
- Practitioners generally found the outcomes-focused approach useful and workable. It also enabled them to be creative
 - The majority of professionals found the outcomes-based documents to be an improvement on the needs-based system and gave broader scope
 - The approach improved choice and control for service users in the assessment process, valued by both service users and professionals. Service users valued the outcomes-based approach because it was clear
 - Practitioners had to diversify how they undertook their assessments to suit service users' situations – one size doesn't fit all
 - Professionals did find themselves discussing areas of someone's life where they were unfamiliar with provision (e.g. education and employment) – training and development may be needed.
- 4 **Outcomes in Community Care Practice** (1997) Nocon, A., Qureshi, H. and Thornton, P., Social Policy Research Unit, University of York
- Social care tends to be concerned with maintenance or prevention rather than change
 - Service users and carers value social contact and company, although responsibility for this may not necessarily rest with social care
 - Comparisons can be made with practice in child care
 - Someone has to set a standard against which to evaluate impact
 - A possible framework may be to measure against 'quality of life'
 - System level changes are required to achieve an outcomes-based approach
- 5 **Shaping Our Lives – From outset to outcome: What people think of the social care services they use** (2003) Shaping Our Lives National User Network, The Joseph Rowntree Foundation
- User-defined outcomes and how to achieve them were difficult to separate – the process of defining outcomes and planning support was congruent
 - Increased time and resources were required to achieve this approach
 - Service users did not feel that their individual outcomes were valued. Respect for individuals was not realised
 - Users valued 'the ordinary things in life' most of all – e.g. shopping (this is reflected in other research). These were not prioritised by services
 - Services working together for example with housing, was valued by users. Their lives are not compartmentalised in the same way as services.
 - Awareness of options is essential – for example service users knowing they can access direct payments – accessible information
 - Service users valued being able to meet other users to share ideas and have a shared voice

6 **An Outcome-Based Approach to Domiciliary Care** (2005), Sawyer, L., Journal of Integrated Care, Volume13, Issue 3

- Interpretation of an outcomes-focused approach varies
- A more individualised service is realised through an outcomes approach
- Improved staff retention
- Challenges
 - Culture change – understanding of concepts
 - Staff in various roles need to be included in training, including finance, contracts, operational teams, providers
 - Need to unlearn from previous rigid ways of working
 - Some providers may miss the structure of prescribed services
 - Care managers may find transfer of control to service users difficult
 - Change in focus for assessments needs to be supported
 - Fear of loss of role – although this is not the case
 - Trust between commissioners and providers and shared ownership
 - Open communication, shared values and goals, shared risk, joint problem-solving, no-blame culture
 - Champions
 - IT and finance systems need to be changed High level (i.e. Directors) support and championing is needed to ensure the support of non-operational teams
 - Champions can reduce anxiety
 - Service Users
 - Most are enthusiastic, but not all
 - Involvement in planning and delivering an outcomes focus is crucial
 - Contracts - May dominate and restrict change
- 'A Checklist for Success' can be found in **Appendix 2**

7 **Outcome Based Commissioning of Home Care: Report of Pilot** (2005) Rainbird, C. and Slasberg, C., Thurrock Council Community Well-Being Directorate.

- Whole service change is needed to implement this approach. Some practitioners were resistant to change and found the adjustment difficult
- Improved overall satisfaction with the service. 100% were either very satisfied, satisfied or quite satisfied with the service.
- Contracts with provider agencies need to include specifications and expectations that providers are committed to this approach (partnership working)
- Training for a wide range of staff on the concept of 'outcomes' – this includes health partners. Training is also needed around assessment and care planning
- Communication between practitioners – commissioners and providers need to improve communication. This is crucial so that commissioners trust provider staff to deliver and so that providers know what expectations they have
- Flexibility within invoicing for care – structures need to be able to deliver changing patterns of support
- Providers reported having to carry out more monitoring visits within an outcomes approach. However, additional hours required to manage outcomes-based support varied from 0 to 7 hours a week
- Staff within provider agencies felt more valued and respected in their work

8 **Outcome Based Care Pilot Project** (2008) Monk, B., Commissioning e-book, Care Services Improvement Partnership

- Project ongoing
- Improvements
 - Improved confidence and self esteem for service users
 - Person-centred care resulting in resources being used flexibly
 - Increased choice and control for individuals
 - Staff feel their work is 'worthwhile' - reduced sickness/improved retention
 - Partnership between the local authority and care provider has improved
- Challenges
 - Cultural change
 - Change in the relationship between service user and provider – greater control to the service user
 - Some service users opted to maintain the traditional service (minority)
 - Single Assessment Process – paperwork doesn't always match up
 - Measuring outcomes defined in the White Paper has proved difficult. Collecting and measuring previously uncaptured information requires direction (Introduction of Common Assessment Framework which is based on the 7 Outcomes should help)
 - Service Users need support in identifying outcomes
 - Paperwork in this pilot proved overwhelming for provider staff
- Learning Points
 - Motivation is crucial, willing partnerships are more likely to succeed
 - Quality of care can be improved through reduced staff turnover
 - Training on the concept of outcomes and delivering outcomes is essential
 - Choice and control should not be transferred to the provider. Trusted providers are essential to success
 - This model can fit with Direct Payments and commissioned services

9 **Using an outcomes approach in the voluntary and community sector: A briefing on the independent evaluation of the first National Outcomes Programme** (2007) Charities Evaluation Service.

- Commissioners of VCOs also need to adopt outcomes thinking
- Weight needs to be given to outcomes in grant making, contracting and reporting requirements
- Outcomes 'champions' were development workers within VCOs, working in geographical areas or specialist networks
 - Most of the Champions implemented outcomes based approach within their own organisations
 - Training received by VCO organisations led to motivation to develop an outcomes focus
- Leadership is crucial and assists ownership, this is a long term change
- There are links to capacity building for VCOs
- Clarity of aims within the organisation is needed
- Build on existing monitoring and evaluation systems
- Where outcomes are easily measured, outcomes focus will be more easily achieved. It may take longer in other settings and smaller organisations
- Training on concepts and delivery are needed

10 **My Home Life: Quality of Life in Care Homes. A Review of the Literature**
(2007) Prepared for Help the Aged by The National Care Homes Research and Development Forum

Section 5 focuses on literature relating to Maintaining Identity and person-centred care which summarises the following from research;

- Living in residential care can threaten an individual's identity
- Staff should seek to learn about people in the context of their whole life
- Treat people as individuals, try to look at the world from the perspective of the individual and create a positive social environment to facilitate well-being
- Communication between staff and residents is crucial
- Biographical approaches can be beneficial to person-centred care. This involves staff, individuals and families gathering information and developing a service tailored to that individual. Memories, life stories, autobiographies are all ways of managing this
- New and old friendships are important. This includes relationships with possessions, places, animals and ideas
- Gender, occupation, ethnicity, spirituality and sexuality are all important to person-centred care
- It is important to consider issues of ethnicity in staff recruitment and training. Translation services and building design is also relevant
- Review of the literature identified a range of barriers to residents' maintaining intimate and sexual relationships. Need to challenge assumptions and consider issues of intimacy for individuals and couple in residential care.
- Support should be given to staff in valuing others, working participatively and overcoming their anxieties

Key Themes

Themes emerge from the research above which include;

- **Local Vision**
 - Ensure a common understanding of terminology
 - Change Management is crucial
 - Shared ownership is needed
 - Leadership and champions within senior posts across partner agencies will support transformation
 - Allocate resources
 - A longer term approach is required
- **Workforce**
 - Outcomes approach generally has a positive impact on commissioners and providers
 - Improved retention of staff and job satisfaction
 - Joint training on concepts and new processes is essential
 - Formalised working relationships assist
 - Need to reassure staff that their roles will not be obsolete, but may change
- **Partnership**
 - A whole system change may be needed, including financial and IT systems so that they don't stall the process
 - Refocus commissioning and delivery of services
 - Needs to be trust between any provider agency and commissioners
 - To capture individual outcome needs, may have to develop new partnerships or areas of knowledge (e.g. housing)
 - Information on definitions and change needs to be clear to staff and users
 - Open communication is needed
 - Flexibility within invoicing systems will help
 - Single Assessment Process not necessarily compatible but paperwork can be adapted or outcomes can be focused in care planning
 - Planning and recording systems will have to change
- **Service Users**
 - Generally report satisfaction with an outcomes approach
 - Receive increased choice, control and flexibility
 - May need support to identify outcomes
 - Respecting individuals is essential
 - The individual should be central to their own plans

Where is there support for outcomes-based working?

Key Questions for you to ask

- Where is the drive and support for an outcomes-based approach?
 - What is happening locally?
 - Do you have pilot projects?
 - Do local partners have pilot projects?
 - Do neighbours have learning to share?
 - Who is your potential 'champion'?
 - What other national or local strategies support this?
- Where is the resistance?
 - Is training needed?
 - Do you have a local vision?
 - Do staff and colleagues understand the concepts?
 - What can be addressed?
 - What questions can be answered?
 - What needs to change? – Think about change management
- Service Users – are they involved?
 - Do you have established means of involving service users?
 - What are they telling you?
 - Can they be involved in piloting new tools or ways of working?
- What works in your favour?
 - What systems do you have in place already?
 - What can stay the same?
- What can you measure against?
 - What evidence gathering do you already do? (surveys, consultation etc.)
 - What else do you need?
 - What hard outcomes do you have to measure?
 - What soft outcomes do you have to measure?

Pilot Projects & Case Examples

I Lancashire and Care UK

Domiciliary care services provided to older people in Lancashire. The pilot is ongoing and looks at the approach to commissioning and providing outcomes-focused domiciliary care services. The pilot is outlined in the commissioning e-handbook, link to the pdf version is below. Lancashire are a partner of **research in practice for adults** and their learning has been used throughout the network. Contact can be made with them if needed.

http://www.integratedcarenetwork.gov.uk/library/C4_Outcome_based_Care.pdf

II Individual Budgets in Coventry: Our Stories (2008) Coventry City Council

Whilst focusing on Individual Budgets, Coventry have developed outcomes-based assessment and planning systems. This amalgamation of case stories outlines their evaluation of the IB Pilot. Copies of this booklet can be requested. Coventry is also one of our partner agencies.

Email: individualbudgetspilot@coventry.gov.uk

Tel: 024 7683 4110

Examples of Coventry's Assessment and Care Planning paperwork can be found in **Appendices 3 & 4**. Coventry are generously willing to share their learning and development, but please acknowledge any use of this material and contact them for the context and further information about this model of working.

III High Impact Changes for Health and Social Care (2008) Care Services Improvement Partnership

'An inspirational collection of organisational initiatives which are changing health and social care services and the lives of the people who use them.'

These examples are directly linked to how different organisations have set out to achieve the 7 outcomes listed in *Our health, our care, our say* and *Transforming Social Care*

<http://www.csip.org.uk/silo/files/hics-doc-11th-march.pdf>

IV Improving Service Delivery: introducing outcomes-based accountability (2006) McAuley, C. and Cleaver, D., Improvement and Development Agency

'A research report commissioned for the IDeA 'better results' programme which supports local councils in their focus on improved outcomes'

Looks at how services have implemented an Outcomes-based Accountability approach within children's services. It details the stages that projects went through and the learning they encountered. This learning is transferable to adult services in many ways.

<http://www.idea.gov.uk/idk/aio/5573454>

Resources and Publications

Social Policy Research Unit

<http://www.york.ac.uk/inst/spru/>

Integrated Care Network, CSIP, Outcome-based commissioning (includes the commissioning e-book which contains case examples and tools)

<http://icn.csip.org.uk/betterCommissioning/index.cfm?pid=853>

Joint Improvement Team

<http://www.jitscotland.org.uk/action-areas/themes/involvement.html>

Adult Care Information Network

<http://www.ic.nhs.uk/our-services/improving-social-care-information/adult-care-information-network>

Care UK

<http://www.careuk.com/homecare4.asp>

This is a list of the resources and publications contained on the following pages;

- I** Designing for outcomes
- II** An approach to outcome based commissioning and contracting
- III** Readiness Tools
- IV** Planning4care – a strategic planning tool
- V** Benchmarking made simple: A step-by-step guide
- VI** Support planning: the essential guide to outcome focused and user directed support planning
- VII** A checklist for success
- VIII** Managing outcomes: a guide for homelessness organisations
- IX** The Treatment Outcomes Profile (TOP): An Implementation Guide
- X** User Defined Service Evaluation Tool
- XI** Sheltered Housing Tenant Self Evaluation Questionnaire
- XII** Assessment and Review Paperwork – Examples
- XIII** A Supported Decision Tool
- XIV** Measuring Outcomes – Examples of Tools
- XV** Developing and Implementing Local ECH Strategies
- XVI** The Logic Model Development Guide
- XVII** My Home Life – Resources
- XVIII** Person-centred Approaches
- XIX** Carers
- XX** Putting People First
- XXI** Planning for transformation framework: stage summaries
- XXII** Thurrock Community Engagement Toolkit

- I Designing for outcomes** (2007) Care Services Improvement Partnership
'A practical resource to support effective design, delivery and evaluation of work in health and social care'

<http://www.csip.org.uk/silo/files/designing-for-outcomes.pdf>

Sections:

- 1 Why focus on outcomes?
- 2 Ways to help you focus on your work on outcomes
- 3 Outcomes focused planning framework
- 4 Outcomes focused planning assessment tool
- 5 Measuring progress on achieving outcomes

- II An Approach to outcome based commissioning and contracting** (2006)
Kerslake, A., Care Services Improvement Partnership, Commissioning e-book, Chapter 9

http://www.integratedcarenetwork.gov.uk/_library/Resources/BetterCommissioning/BetterCommissioning_advice/Chap9AKerslake.pdf

Sections:

- 1 Example of Model of Practice
- 2 A framework for implementing outcome-based commissioning and contracting
- 3 Issues to be tackled in developing an outcome-based approach
- 4 Benefits of an outcome-based approach

- III Readiness Tools** – Better Commissioning LIN, CSIP, Integrated Care Network

<http://icn.csip.org.uk/betterCommissioning/index.cfm?pid=1001>

- IV Planning4care – a strategic planning tool** (2008) Gosling, D., Commissioning e-book, Integrated Care Network, CSIP

http://icn.csip.org.uk/_library/C5_Planning_for_Care.pdf

Sections:

- 1 What does planning4care contain?
- 2 Data contributing to needs estimates
- 3 Data contributing to resource analysis
- 4 Using Planning4 care

V Benchmarking made simple: A step-by-step guide (2008) A Performance Hub Guide

<http://www.ces-vol.org.uk/downloads/benchmarkingmadesimple-231-238.pdf>

Sections:

- 1 Getting Started
- 2 Gathering the Information
- 3 Sharing the Information with Others
- 4 Using the Information

VI Support Planning: The essential guide to outcome focused and user directed support planning (2007) Sawyer-James, R., The Sheltered Housing Network

<http://www.shn.org.uk/The%20Essential%20Guide%20to%20Outcome%20Focused%20and%20User-Directed%20Support%20Planning.htm>

Sections:

- 1 The Support Planning Process in Sheltered/Supported Housing
- 2 Sheltered Housing – Independence or institution
- 3 Identifying Needs and Risks when Assessing Support Needs
- 4 User-Directed Support Planning
- 5 What needs to be in a Support Plan?

VII A Checklist for Success. An Outcome-Based Approach to Domiciliary Care (2005), Sawyer, L., Journal of Integrated Care, Volume13, Issue 3. (See [Appendix 2](#))

<http://www.well-beingandchoice.org.uk/outcomesLS.pdf>

VIII Managing Outcomes: A guide for homelessness organisations (2003) Charities Evaluation Services

This document may be focused for homelessness organisations, but it takes a step-by-step method to identifying, assessing and evaluating outcomes.

<http://www.ces-vol.org.uk/downloads/managingoutcomes-16-22.pdf>

Sections:

- 1 Identifying Outcomes
- 2 Monitoring Outcomes
- 3 Using Outcome Information Well
- 4 Making it Work

IX The Treatment Outcomes Profile (TOP): An Implementation Guide for Managers (2007) The National Treatment Agency for Substance Misuse, NHS

http://www.nta.nhs.uk/areas/outcomes_monitoring/docs/TOP_manager%27s_guide_010607.pdf

Sections:

- 1 What is the Treatment Outcomes Profile
- 2 Implementation of the TOP
- 3 Checklist for Managers
- 4 Appendix: Publications and other resources to support implementation of the TOP

In addition there is also a guide for keyworkers which includes an assessment profile.

http://www.nta.nhs.uk/areas/outcomes_monitoring/docs/TOP_keyworker_guide_270907.pdf

X User Defined Service Evaluation Tool (UDSET) Scotland

This toolkit has been developed by the Joint Improvement Team in Scotland. A copy of the User Defined Service Evaluation Questionnaire can be found in **Appendix 6**. However, this should be used together with the guidance described on the website, which also contains other useful materials.

<http://www.jitscotland.org.uk/action-areas/themes/involvement.html>

XI Sheltered Housing Tenant Self Evaluation Questionnaire

This is an example of a questionnaire used within a sheltered housing complex to measure outcomes. It can be found in **Appendix 8**.

XII Assessment and Review Paperwork – Examples

Appendices 3 and 4 contain examples of the assessment and care planning paperwork used by Coventry City Council based on an outcomes framework.

Appendix 7 shows the Orkney Islands review paperwork based on an outcomes approach. The details of this case example can be found here - <http://www.jitscotland.org.uk/action-areas/themes/involvement.html> .

Lancashire County Council

Care Plan

http://www.ic.nhs.uk/webfiles/Services/Social%20care/ASCID/ACIN%20meetings/Lanc%20OutcomeFrameworkDocuments_v2_.pdf

Review 1

http://www.ic.nhs.uk/webfiles/Services/Social%20care/ASCID/ACIN%20meetings/Lanc%20QuestionnairePart1_v2_.pdf

Review 2

<http://www.ic.nhs.uk/webfiles/Services/Social%20care/ASCID/ACIN%20meetings/QuestionnairePart2and3.pdf>

Assessment process documents developed in Scotland can be found here;

<http://www.jitscotland.org.uk/action-areas/themes/involvement/support-materials.html>

This includes paperwork developed by North Lanarkshire (see **Appendix 15**) and East Renfrew.

XIII A Supported Decision Tool (2007) Independence, choice and risk: a guide to best practice in supported decision making (Annex A), Department of Health

This is a document focusing on supporting people to make everyday choices. This DoH document also contains a tool for practitioners to use in assessment and care planning.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074773

Sections:

- 1 Using the Tool
- 2 Issues for the Practitioner to Consider
- 3 Supported Decision Tool

XIV Measuring Outcomes – Examples of Tools

The 'Recording Outcomes in Community Care Services Measurement Tool' (ROCCS) is available in **Appendix 5**. The full tool is *not* shown here. This first section is provided as an example of how the tool works. To use this measurement tool, please contact Nicola Russell-Brooks. Email: nicola@logriders.co.uk Tel: 01239 698411. Do not use without permission.

Lancashire County Council has posted many resources around developing an outcomes focus under the Adult Care Information Network website. Accessed here;

<http://www.ic.nhs.uk/our-services/improving-social-care-information/adult-social-care-information-development/adult-care-information-network/measuring-outcomes-for-service-users>

Bromford House Outcome Monitoring Record Sheet is in **Appendix 9**. Their supporting documentation can be found in **Appendix 10**.

The Logic Model Handbook 2007 follows one model that can be used for establishing and developing measurements and indicators for outcomes-based approaches. **Appendix 11** shows one section of the handbook '*selecting outcomes you want to measure*'.
http://www.vsuw.org/site/DocServer/Logic_Model_Handbook_Updated_2007.pdf?docID=801

Outcomes Star – **See Appendix 12**. This is used by the service user and care manager to plot their current position and where they would like to be on a range of areas in their lives. These 'scores' can be tracked individually or as groups to measure impact. The

accompanying indicators have been developed by St Mugs. However the concept can be adapted to suit different areas of work.

FACE (Functional Analysis of Care Environments) offers 'Outcomes Software' which supports 'management and analysis of complex personal information in the health and social care environment'. http://www.facecode.com/outcomes_software.html

XV Developing and Implementing Local Extra Care Housing Strategies (2003)
Housing LIN, DoH

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4119310

Sections:

- 1 Mapping Populations
- 2 Mapping Resources
- 3 Partnerships
- 4 Local Management of Services
- 5 Funding and Finance
- 6 Quality and outcome measurement

XVI The Logic Model Development Guide (2004) W.K. Kellogg Foundation, USA

This is a method of developing an outcomes-focused approach based on work in the USA.

Sections:

- 1 Introduction to Logic Models
- 2 Developing a basic Logic Model for your Program
- 3 Developing a Theory-of-Change Logic Model for your Program
- 4 Using you Logic Model Plan for Evaluation
- 5 Resources

<http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf>

XVII My Home Life - Resources

"**My Home Life** is a collaborative programme aimed at improving the quality of life of those who are living, dying, visiting and working in care homes for older people. Working in partnership with the care home sector, **My Home Life** is undertaking a range of educational activities to assist everyone in this field to share best practice and enhance quality of care."

My Home Life – Maintaining Identity Bulletin

http://www.myhomelife.org.uk/resources/mhl_bulletin_2.pdf

The My Home Life programme follows an outcomes-focused approach to residential care services under 8 principles, which are;

- [Managing transitions](#)
- [Maintaining identity](#)
- [Creating community](#)
- [Sharing decision-making](#)
- [Improving health & healthcare](#)
- [Supporting good end-of-life](#)
- [Keeping workforce fit for purpose](#)
- [Promoting a positive culture](#)

XVIII Person-centred Approaches, Valuing People Support Team, CSIP

<http://valuingpeople.gov.uk/dynamic/valuingpeople140.jsp>

Sections:

- 1 Guidance for partnership boards
- 2 More checklists and guides
- 3 Help for person centred planning co-ordinators
- 4 This is my life
- 5 More Resources

XXIII Carers

Lancashire County Council – Outcomes for Carers Assessment

<http://www.ic.nhs.uk/webfiles/Services/Social%20care/ASCID/ACIN%20meetings/OutcomeQuestionnaireaug06.pdf>

Appendix 16 shows Orkney Island’s Carer Review paperwork.

<http://www.jitscotland.org.uk/action-areas/themes/involvement.html>

XX Putting People First – Personalisation Toolkit (2008), Single Assessment processes and personalisation. Challenges, emerging practice, options and possibilities, Integrated Care Network

http://www.icn.csip.org.uk/library/Resources/Personalisation/Personalisation_advice/Single_assessment_processes_and_personal_budgets_Challenges_emerging_practice_options_and_possibilities.pdf

Includes practice examples.

Sections:

- 1 Underpinning Principals
- 2 Challenges
- 3 Emerging Practice
- 4 Options/possibilities

XXI Planning for Transformation Framework: Stage Summaries

<http://networks.csip.org.uk/Personalisation/PersonalisationToolkit/?parent=3087&child=3221>

XXII Thurrock Community Engagement Toolkit

http://www.thurrock.gov.uk/i-know/consultation/pdf/engagement_toolkit_v011.pdf

Thurrock are committed to an outcomes-based approach, their website includes Commissioning Plans, which can be found here; <http://www.thurrock.gov.uk/socialcare>

Training

The following people may be willing to speak at conferences organised by Local Authorities. They should be approached directly and have no particular affiliation to **research in practice for adults**.

Research in practice for adults has planned events for practitioners, senior practitioners and colleagues. These will be two part events, the first day concentrating on outcomes-focused assessments, and the second day focusing on outcome-based planning. Attendees are expected to attend both days.

Exeter – 2nd and 10th December 2008

Birmingham – 12th and 20th May 2009

Please see the Learning Event Programme for further details and look out for flyers.

<http://www.ripfa.org.uk/learningevents/2008-9/oac.asp?catID=8>

During the year 2007 – 2008, two events were held on commissioning and contracting for outcomes. The presentations for these events can be found here:

<http://www.ripfa.org.uk/learningevents/cfo.asp?catID=8&subcat=15>

Potential speakers/trainers/packages

- I **Doug Gosling**, Independent Social Care Consultant
dugosling@aol.com

Click here to see a podcast featuring Doug:

<http://www.integratedcarenetwork.gov.uk/betterCommissioning/index.cfm?pid=863&catalogueContentID=2398&type=wmv>

- II **Philippa Codd**, Care UK, Business Development Director
philippa.codd@careuk.com

Philippa is working on outcomes based care within a provider setting and may prove a useful link for providing a case example through their pilot with Lancashire County Council. Her colleague Libby Eastleigh may also be able to support.

<http://www.careuk.com/busdevdir.asp>

- III Professor **Caroline Glendinning**
cg20@york.ac.uk

Outcomes-focused services for older people. York University. Contact details can be found here; <http://php.york.ac.uk/inst/spru/profiles/cg.php>

- IV **Nick Miller**, Lead Analyst, Performance Measures, CSCI
nick.miller@csci.gsi.gov.uk

http://www2.warwick.ac.uk/fac/soc/shss/mrc/olderpeople/outcome_focused/nick_miller.pdf

- V Coventry City Council and Lancashire County Council

Both are **research in practice for adults'** Partner agencies. These are links who may be able to suggest speakers or support.

Coventry – **Andrew Reece**, andrew.reece@coventry.gov.uk

Lancashire – **Gary Roberts**, Gary.Roberts@SSD.LancsCC.Gov.Uk

Thurrock Council and Northamptonshire County Council may also be able to help with case examples although they are not part of **research in practice for adults'** network.

Andrew Jepps Service Manager -Northamptonshire ajepps@northamptonshire.gov.uk

Les Billingham – Thurrock Lbillingham@thurrock.gov.uk

- VI **Nicola Russell-Brooks**, Development Consultant

Some of her work can be found in **Appendix 5**. Nicola works with both local authorities and provider services on developing outcomes-focused plans and evaluations. Her company name is Logriders. She can be contacted here;
nicola@logriders.co.uk

- VII **Liz Cairncross**, Head of Research, Institute of Public Care

Liz wrote the Key Issues publication for research in practice for adults, which can be found here:

http://www.ripfa.org.uk/publications/keyissues/keyissuesPDF/ripfa%20keyissues_01.pdf

- VIII **Michael Patterson**, Support Solutions

Whilst predominantly focusing on housing support, Michael and his team could contribute to an outcomes based event, particularly around 'outcomes measurement'. Their list of consultants can be found here;

<http://www.supportsolutions.co.uk/consultancy.htm>

- IX Training Package – **Using The Outcomes Star**

See **Appendix 13**. Please note the Copyright. This provides guidance on providing in-house training for using the outcomes star.

X **Outcomes Champions**

Trained by the Charities Evaluation Service, Outcomes Champions provide training to VCOs on understanding and using an outcomes focus. They operate regionally and can provide training to other organisations at a cost.

Click here for contact details:

<http://www.ces-vol.org.uk/index.cfm?pg=71>

XI **Institute of Public Care**

Offer consultants and knowledge transfer. They also offer seminars which include outcomes-based contracting.

<http://ipc.brookes.ac.uk/consultancy/default.htm>

XII **Dementia Training**

Accredited trainers. Will tailor make packages. Person-centred dementia care included.

<http://www.dementiatrainers.co.uk/overview.htm>

The Alzheimer's Society also offers training packages around dementia and person-centred care.

<http://www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200307>

XIII **Outcomes-focused Evaluation**

Module 5 of the Barnardo's Evidence Guide. The entire resource comes as a series of 5 packs, including a learner's pack and trainer notes. Module 5 includes the purpose of evaluation, setting indicators and measuring outcomes, planning and choosing tools. Barnardo's offer training to go alongside the packs or the packs can be bought from them.

This is transferable across adult and children's services.

http://www.barnardos.org.uk/resources/research_and_publications/theevidenceguide

Appendix 1

Population Accountability – For Whole Populations in a Geographic Area

The 7 Population Accountability Questions

1. What are the quality of life conditions we want for the children, adults and families who live in our community?
2. What would these conditions look like if we could see them?
3. How can we measure these conditions?
4. How are we doing on the most important of these measures?
5. Who are the partners that have a role to play in doing better?
6. What works to do better, including no-cost and low-cost ideas?
7. What do we propose to do?

Performance Accountability – For Services, Agencies and Service Systems

The 7 Performance Accountability Questions

1. Who are our customers?
2. How can we measure if our customers are better off?
3. How can we measure if we are delivering services well?
4. How are we doing on the most important of these measures?
5. Who are the partners that have a role to play in doing better?
6. What works better, including no-cost and low-cost ideas?
7. What do we propose to do?

Appendix 2

A CHECKLIST FOR SUCCESS

- Clear vision
- Scope the project
- Ensure there is a project leader
- Support from a 'champion'
- Secure the environment
 - Consultation with users, providers and other stakeholders, and amend plan if appropriate
 - Develop relationships – purchaser/provider
 - Tender – evaluate and select providers
 - Plan and provide training for care managers, provider managers and care workers
- Develop appropriate documentation
- Ensure outcomes express service user experience and expectations
- Evaluation

Sawyer, L. (2005) *An Outcome-Based Approach to Domiciliary Care*, Journal of Integrated Care, Volume13, Issue 3

Appendix 3 – Coventry City Council – Assessment Paperwork

INDIVIDUAL BUDGETS PILOT OUTCOMES ASSESSMENT FRAMEWORK		αβχ	
<u>DRAFT; OUTCOMES FOCUSED ASSESSMENT</u>			
Date of referral		Date assessment commenced	
Source of referral		Date form completed	
Service User's Address		Temporary Address;	
Telephone number		e-mail address;	
Mobile		Date of birth	
Religion		Ethnicity / culture	
Important relationships			
Contact details			
Note of communication / access requirements			
Name of assessor;		Team/Service of Assessor	

Summary of situation as seen by service user and carer (including current service provision where applicable)
Lives alone YES <input type="checkbox"/> NO <input type="checkbox"/>

The SPRU Outcomes Framework; to be used as a prompt to ensure all outcome areas are considered in the assessment.

<p style="text-align: center;">AUTONOMY OUTCOMES</p> <p style="text-align: center;">Access to all areas of home Access to locality + wider environment Communication, direct and control Financial security Home Maintenance</p>	<p style="text-align: center;">PERSONAL COMFORT OUTCOMES</p> <p style="text-align: center;">Personal hygiene Safety Security Desired level of cleanliness of home Emotional well being Physical health</p>
<p style="text-align: center;">ECONOMIC PARTICIPATION OUTCOMES</p> <p style="text-align: center;">Access to paid employment as desired Access to training Access to further/higher education to secure employment Access to appropriate training for new skills (e.g. lip reading)</p>	<p style="text-align: center;">SOCIAL PARTICIPATION OUTCOMES</p> <p style="text-align: center;">Access to mainstream leisure activities Access to support in parenting role Access to support for personal relationships Access to advocacy/peer-support Citizenship</p>

Outcomes are the end results, goals and achievements, which may be supported by service provision

Outcomes may be seen as;

Maintenance Outcomes; eg maintaining personal comfort, staying in work

Change Outcomes; eg getting a job, developing new skills

Process Outcomes; service delivery supports personal dignity or cultural needs

See also guidance notes about how minor equipment and supporting people tasks fit within the Outcomes Framework

High level outcome desired by the Service User or Carer

High level outcome desired by the Service User or Carer				
Smaller outcomes (sub-goals) to be met	Evidence of any risk that may be associated with not supporting this outcome	Who will assist the service user to achieve each of these outcomes?	Priority rating for funding organization	Priority rating for service user/carer
			Rate* 1, 2, 3 or 4	

Priority Score; 1= Critical 2= Substantial 3=Medium 4=Low (equating to Eligibility Criteria for Social Care Support)

High level outcome desired by the Service User or Carer

High level outcome desired by the Service User or Carer				
Smaller outcomes (sub-goals) to be met	Evidence of any risk that may be associated with not supporting this outcome	Who will assist the service user to achieve each of these outcomes?	Priority rating for funding organization	Priority rating for service user/carer
			Rate* 1, 2, 3 or 4	

Priority Score; 1= Critical 2= Substantial 3=Medium 4=Low (equating to Eligibility Criteria for Social Care Support)

Does the service user agree to assist in achieving these outcomes? YES NO

Does the carer agree to assist in achieving these outcomes? YES NO

Does the worker agree that these outcomes should be planned for? YES NO

Summary Of Areas Of Risk And Risk Management Discussed. Use this box to present evidence of how eligibility criteria are met. (Please Attach Relevant Risk Assessments)

Who participated in this assessment?

Name	Role	Telephone	Address	e-mail

Is the carer eligible for separate assessment?

Yes No

Note arrangements to be made if the carer would like a separate assessment:

Summary of assessor

**Specialist Assessments
Required**

Independent Living Fund

Yes No

Major Equipment or Housing Adaptations

Yes No

Access to Work

Yes No

Other Specialist Assessment (chose)

Drop Down List

Signature of Service User

Signature of Carer

Signature of assessor

Date

Date

Date

Comments of person who can authorize funding

Signature

Date

Appendix 4 – Coventry City Council – Support Plan

INDIVIDUAL BUDGETS PILOT OUTCOMES ASSESSMENT FRAMEWORK		αβχ
<u>DRAFT; SUGGESTED OUTCOMES FOCUSED SUPPORT PLAN</u>		
Name; Address;	Date of birth: Contact Number;	
Date Suggested Support Plan agreed:	Suggested support agreed by:	Date for review:
Name of support plan co-ordinator:	Contact telephone number:	
Service user requires this care plan in: Braille <input type="checkbox"/> Audio tape <input type="checkbox"/> BSL video <input type="checkbox"/> Community language <input type="checkbox"/> (<i>please specify:</i>)	Method chosen to manage support Direct Payment <input type="checkbox"/> 3 rd Party Direct Payment <input type="checkbox"/> Independent Living Trust <input type="checkbox"/> Care Navigator (not yet available) <input checked="" type="checkbox"/> Care Brokerage <input type="checkbox"/> Care Management <input checked="" type="checkbox"/>	

Service user's signature:	Assessors Signature:
Date	Date

Outcomes are the end results, goals and achievements which may be supported by service provision

SMALLER OUTCOMES (sub-goals) to be met	WHAT will be done?	WHO will do it	By when?	Amount of funding to be applied for	Source of funding	COST to the service user
High Level Outcome 1.						
(a)						
(b)						
(c)						
High Level Outcome 2.						
(a)						
(b)						
(c)						
High Level Outcome 3.						
(a)						
(b)						
(c)						

SMALLER OUTCOMES (sub-goals) to be met	WHAT will be done?	WHO will do it	By when?	Amount of funding to be applied for	Source of funding	COST to the service user
High Level Outcome 4.						
(a)						
(b)						
(c)						
High Level Outcome 5.						
(a)						
(b)						
(c)						
High Level Outcome 6.						
(a)						
(b)						
(c)						

This Support Plan aims to support you to achieve the outcomes agreed above. It will be regularly reviewed with you. If the outcomes you wish to achieve change, the support you receive may also need to change.

Total value of on going support agreed per week	
Total Service user contribution per week	
Total value of one off support agreed	

Please record here any specific information that service providers should know about my preferences about how my support is delivered
Please record here any specific information that service providers should know in order to be able to work with me to appropriately manage risk

Appendix 5

ROCCS (Recording Outcomes in Community Care Services) – The Measurement Tool

This document is registered with the UK Copyright Service; Registration No:280591, it cannot be used without the prior agreement.

Instructions

The Context

This tool is used as part of the assessment, planning and review process. The client will agree with the assessor what they want to achieve (the priority outcomes) as a result of receiving a service. These priority outcomes will then be translated into output information and input information on the care plan.

The client is first assessed on entry into the service, and then at frequent and regular intervals there after (not less than 6 monthly).

The information required to score the level of functional ability against each outcome domain is collected through the normal exchange of information integral to an effective assessment and review process.

The member of staff responsible for scoring the client's level of ability can complete the score at the meeting with the client OR in the office later, but they must have evidence that correlates to the basket of indicators to demonstrate achievement at a level within their assessment.

The client must be informed before they agree to receive a service that this tool is used to monitor your progress in meeting their needs, and the tool must be explained to them, with a copy of the tool provided before the first assessment takes place, and the client must be advised of the score attached to their assessment and subsequent reviews to enable them to agree the outputs on their care plan and any subsequent changes on review.

On assessment the score is recorded onto the care plan against the outcome domains agreed as priority areas for action through the care plan, and subsequent scores are recorded on review.

The Scoring

The level at which the client will be assessed other than indicator 1 and 5 is determined by the hourly level of support/care provided to that client per week where any part of this time is used to support them in the indicator areas identified.

At level 1 the client must have not been in receipt of support in this area for the last review period and fully meet the criteria set identified in red for each outcome to be assessed as having achieved this level.

At level 5 the client's circumstances must fit the identified criteria identified in red for each outcome to be recorded at this level irrespective of whether support is currently being provided or not.

Outcome 1: Being Healthy (Physical)

To maintain or improve the physical health and well being of clients.

Indicator 1

The client is maintaining their physical health and well being independently.

Basket of Indicators to be used as evidence; the staff member must have evidence that the client has achieved the outcomes recorded in red as a minimum to achieve this level and where appropriate that the client has achieved any of the other indicators at this level as appropriate to the outputs on their care plan.

- Client is registered with a GP and attends without support
- Client takes prescribed medication without any support.
- Client can access specialist services without any support when required to manage their physical well being (including substance misuse services and mental health services)
- Client has not experienced an unplanned admission to hospital as a direct result of a fall in the last six months.

Indicator 2

The client is maintaining their physical health and well being with a minimum level of support in this area of their life per week.

Basket of Indicators to be used as evidence; Any client who is receiving under 2 hours of support per week with any of the following to maintain/improve their health and well-being will be recorded as having achieved level 2.

- Client is registered with a GP and attends with support
- Client takes prescribed medication with support.
- Client can access specialist services with support when required to manage their physical well being (including substance misuse services and mental health services)
- Client has not experienced an unplanned admission to hospital as a direct result of a fall in the last six months and is supported to manage their safety in their own home or in the community (Client is prompted to use mobility equipment and adaptations safely and requires personal support with their mobility to access community services)

Indicator 3

The client is maintaining their physical health and well being with an average level of support in this area per week.

Basket of Indicators to be used as evidence; Any client who is receiving between 2 and 5 hours of support per week with any of the following to maintain/improve their health and well-being will be recorded as having achieved level 3.

- Client is registered with a GP and attends with support
- Client takes prescribed medication with support.
- Client can access specialist services with support when required to manage their physical well being (including substance misuse services and mental health services)
- Client has not experienced an unplanned admission to hospital as a direct result of a fall in the last six months and is supported to manage their safety in their own home or in the community (Client is prompted to use mobility equipment and adaptations safely and requires personal support with their mobility to access community services)

Indicator 4

The client is able to maintain their physical health and well being with a maximum level of support per week.

Basket of Indicators to be used as evidence; Any client who is receiving over 5 hours of support per week with any of the following to maintain/improve their health and well-being will be recorded as having achieved level 5.

- Client is registered with a GP and attends with support.
- Client takes prescribed medication with support.
- Client can access specialist services with support when required to manage their physical well being (including substance misuse services and mental health services)
- Client has not experienced an unplanned admission to hospital as a direct result of a fall in the last six months and is supported to manage their safety in their own home or in the community (Client is prompted to use mobility equipment and adaptations safely and requires personal support with their mobility to access community services)

Indicator 5

The client is not currently able to maintain their physical health and well-being.

Basket of Indicators to be used as evidence; If any of the following indicators are identified as a match for the client being assessed they will be recorded at level 5.

- Client is not registered with a GP
- Client will not take their prescribed medication.
- Client will not access specialist services with support when required to manage their physical well being (including substance misuse services and mental health services)
- Client has experienced an unplanned admission to hospital as a direct result of a fall in the last six months.

Appendix 6 – User Defined Service Evaluation Questionnaire

User Defined Service Evaluation Questionnaire

Section 1. The nature and extent of support provided.

This section should be kept as brief as possible.

1. Can you tell me about the kind of help that you get from (name of service / partnership)?
Look for the 'facts':
Tasks get help with,
how often,
who by
(may need to prompt with name of service providers if known.)
2. Do you get support from anywhere else?

Section 2. Impact on you and your life

There are several things that people have said that are particularly important in life. These are: feeling safe, seeing other people, having things to do, living life as you want as well as where you want and staying as well as possible, avoiding discrimination. Can you tell me if (name of service) and the support that they give you makes a difference to you and your life...in respect of:

- Feeling safe
 - Seeing other people
 - Having things to do
 - Living life the way you want
 - Living where you want
 - Staying as well as you can be
 - Avoiding discrimination / stigma
3. Is there anything else that you think that the service could or should do?
 4. What difference has using this service made to your life?

In this question probe for change outcomes: improved symptoms; increased confidence and skills; increased mobility.

Section 3. What happens when you use the service

For each question probe for what people in the service do and don't do, and ask for specific examples where possible.

5. Do people in the service listen to you and take into account your own needs, wishes and circumstances?
6. Do people in the service value you and treat you with respect?
7. Do people in the service generally do what they say they will?
8. Do you have choice over the kind of help you get and when you get that help?
9. Are people responsive to your needs and wishes?
10. Is there anything that you would like people in the service to do differently?

Section 4. Your thoughts on the service overall

11. Are there ways in which the service could be improved for you?
12. How easy is it to get the service?
13. Have there been any delays in getting help or support from this service?
14. Is there anything else you would like to tell me about (name of service)?
15. Do you have any questions about this interview?

Close

Analysis Pro-forma

Background Information

Name of Service user / Carer	Anonymised code
Name of Interviewer	Date
Informed Consent obtained?	Audio recording?
Other relevant information and reflections	

Outcome Checklist

Outcome	Experience of service user / carer	Features of service promoting or hindering that outcome
Quality of life outcomes		
Safety		
Having things to do		
Social Contact		
Staying as well as you can be		
Living life as you want / where you want		
Dealing with discrimination		
Other		
Process outcomes		
Being listened to		
Valued and treated with respect		
Choice		
Reliability		
Responsiveness		
Other		
Change outcomes		
Improving skills and confidence		
Improved mobility		
Other		

<http://www.jitscotland.org.uk/action-areas/themes/involvement.html>

Appendix 7 – Orkney Islands Review Paperwork

ORKNEY ISLANDS COUNCIL DEPARTMENT OF COMMUNITY SOCIAL SERVICES & NHS ORKNEY

OUTCOMES FOCUSED REVIEW FORM

Client's Name:		Date of review:			
Current Address:	Tel No:	CHI:			
		PARIS:			
		File:			
Post Code:	Mobile No:				
Worker Responsible for Review:		Services Used:			
Reason for review:		Date of any previous reviews in last 2 years:			
Changes in circumstances since last assessment / review:					
Are there any concerns that the client has or may shortly have difficulties in managing their own financial affairs or making decisions due to incapacity under the Adults with Incapacity (Scotland) Act 2000? Give an indication of which other agencies have been asked to contribute to their view.					
What is the view of the client and his/her family carer(s) relating to the above?					
PERSONS CONTRIBUTING TO THE REVIEW			DATE & METHOD OF CONTRIBUTION		
Name:	Designation / Relationship	Phone	Letter/ report	Individual meeting	Attend review
Service User's Signature:			Date:		
Workers Signature:			Date:		
SENIOR WORKERS RECOMMENDATION:					
Signed:			Date:		

PERSON RESPONSIBLE FOR NEXT REVIEW:	
Date of Next Review:	
Details input to Database: YES/NO Date of input:	
PROCESS OUTCOMES:	
To what extent does the client feel that staff within the service / services:	
Listen to them	Give them a choice over the nature and timing of support
Respect them as an individual (including addressing issues of discrimination and stigma, if appropriate)	Do what they say they will
Are responsive to their needs and wishes	
QUALITY OF LIFE OUTCOMES:	
What difference does the service make to the client's life in respect of:	
Taking part in activities of their choice (including employment and training if appropriate)	
Social contact	Staying as well as they can be (Including general health and wellbeing)
Living where they want	Feeling safe (Physical- neighbourhood, home, services. Emotional- feeling at ease, knowing someone will be there for you)

Daily living skills, confidence and mobility

OVERALL

To what extent is the service / package of support delivering the outcomes that the client wants?

What changes would the client / carer / other most like to see?

What can be changed to deliver these outcomes?

What must be changed to meet the needs of the client?

Is the review of outcomes derived from the clients own reports? If not, what information has been provided and by whom?

OUTCOMES SUMMARY

Based on the client's own response where possible, please highlight answers to the following questions:

Is the client supported by their package of care to feel physically and emotionally safe in their own home and environments where community care services are provided?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with their involvement in their package of care thinking particularly about whether they have choice, have been supported to make their own decisions and have the information needed to do so?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Engage in leisure and social activities of their choice?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Take part in activities of their choice (including employment and training if appropriate)?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Have social contact with others?

Strongly agree Agree Disagree Strongly disagree Not applicable

DETAILS OF UNMET NEED:

Unmet Need Form Submitted to:

Date:

DETAIL ANY NEW RISK ASSESSMENT:

Community Care Plan as agreed by review:

Original Care Plan date:

Actions required	By whom?	Is this a change?	Signature	Date
Essential				
Desirable				

Comments/other information:

Appendix 8

SHELTERED HOUSING TENANT SELF-ASSESSMENT QUESTIONNAIRE

Our aim is to promote independence and choice through quality housing and support. *(Provider organisations to add in more on their specific aims as desired).* Like many other sheltered housing providers *(Name of organisation)* would like to know if you feel that we achieve these aims.

We would therefore like to ask you (and other tenants) some questions on a regular basis (at least yearly) to help us measure if we are achieving our aims. This will also help to tell us what parts of our service we need to improve. *(Providers may wish to add that this questionnaire will be given to tenants every time a Support Plan is reviewed)*

We would appreciate it if you could fill in this form for us. You can do this yourself or if you prefer, with assistance from a relative or friend and post it back to us in the enclosed self-addressed envelope. Or you may complete the form with the assistance of the scheme manager or other member of staff who will return it to us for you – it is your choice.

We will ensure that, in accordance with the Data Protection Act and the Supporting People Quality Assessment Framework, the information you give us will be treated with great care, confidentially and will only be used to improve services to you.

Background Information

Name		Age		Sex	
------	--	-----	--	-----	--

Ethnic origin and language

White British	<input type="checkbox"/>	Other White	<input type="checkbox"/>	Mixed	<input type="checkbox"/>	Asian	<input type="checkbox"/>	Black	<input type="checkbox"/>	Chinese	<input type="checkbox"/>	Other	<input type="checkbox"/>
---------------	--------------------------	-------------	--------------------------	-------	--------------------------	-------	--------------------------	-------	--------------------------	---------	--------------------------	-------	--------------------------

Please state your first language:	
-----------------------------------	--

Your Accommodation

Flat number		Scheme name		Type of scheme	
-------------	--	-------------	--	----------------	--

(sheltered / extra care / neither)

Where would you be living now if sheltered housing had not been available?

In my own home	<input type="checkbox"/>	With family	<input type="checkbox"/>	In residential or nursing care	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>	
----------------	--------------------------	-------------	--------------------------	--------------------------------	--------------------------	----------------------	--------------------------	--

Are you completing this questionnaire: *(Providers may delete or amend options as appropriate)*

Alone	<input type="checkbox"/>	or with the help of a:	family member	<input type="checkbox"/>	friend	<input type="checkbox"/>	scheme manager	<input type="checkbox"/>	housing officer	<input type="checkbox"/>
-------	--------------------------	-------------------------------	---------------	--------------------------	--------	--------------------------	----------------	--------------------------	-----------------	--------------------------

There are no right or wrong answers to the following questions¹. Please tick your answer for each question according to how you feel right now.

Section one: quality of life		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1.	I feel that I am independent					
2.	I feel that I enjoy life					
3.	I feel that I am confident					
4.	I am in control of my life					
5.	I am listened to					

Section two: health		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
6.	I am in good physical health					
7.	I am in good mental health					
8.	I have a healthy diet					
9.	<i>The support I receive from (name of organisation) has helped to prevent me falling</i>					
10.	<i>The support I receive from (name of organisation) has helped to prevent me going into hospital</i>					
11.	<i>The support I receive from (name of organisation) has helped to prevent me going into residential/nursing care</i>					

Section three: Social networks and involvement		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
12.	<i>I am involved with people who live in the scheme</i>					
13.	I am involved with people in the wider community					
14.	<i>I am involved with the running of the scheme</i>					

Section four: Skills and hobbies		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
15.	I regularly participate in hobbies					
16.	I have the opportunity to learn new skills					
17.	I am involved with health activities (such as exercise classes)					

Section five: Environment		Strongly agree	Agree	Neither agree nor	Disagree	Strongly disagree
---------------------------	--	----------------	-------	-------------------	----------	-------------------

¹ The questions in italics do not apply to those living outside sheltered housing

				disagree		
18.	I feel safe and secure					
19.	Aids, adaptations and technology enable me to live independently (e.g. community alarm system, buggies, grab rails, a level access shower, assisted bathing room, CCTV etc.)					
20.	My accommodation is designed to meet my needs					

Section six: Dealing with finances and administration		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
21.	I have received increased financial/welfare benefits as a result of support in claiming					
22.	I have easy access to information and advice services for older people					
23.	I am able to express views and complaints					
24.	When needed, I have sufficient practical help to:					
	a. fill in forms or help me with correspondence					
	b. speak to Social Services					
	c. speak to Housing Benefits					
	d. make appointments to see a doctor, nurse, social worker or solicitor					

Section seven: Cultural and religious needs		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
25.	I feel that my religious/spiritual needs are met					
26.	I feel that my cultural needs are met					

Thank you for taking the time to fill in this form. Your views count.

Providers may wish to add a final open ended question such as “Is there anything else you would like to add regarding the service you receive?” or “Do you have any further comments about how the service you receive could be improved to give you more independence and choice?”

Appendix – 9 – Bromford House Outcome Monitoring Record Sheet

Outcome Monitoring - Record Sheet

SUPPORT WORKER	<input type="text"/>
SERVICE USER	<input type="text"/>
SERVICE USER REF	<input type="text"/>
ADDRESS	<input type="text"/>
DATE	<input type="text"/>

Please complete for ALL service users

Please fill in the following section of the form in accordance with the guidance provided. Please record the score as a joint decision between service user and worker.

Q1. Education and Training:

1 2 3 4 5 6 7 8 9 10

Q2. Independent Living Skills:

1 2 3 4 5 6 7 8 9 10

Q3. Social Networks:

1 2 3 4 5 6 7 8 9 10

Q4. Work:

1 2 3 4 5 6 7 8 9 10

Q5. Community Networks:

1 2 3 4 5 6 7 8 9 10

Q6. Health:

1 2 3 4 5 6 7 8 9 10

Q7. Money:

1 2 3 4 5 6 7 8 9 10

Q8. Parenting Skills:

1 2 3 4 5 6 7 8 9 10

Q9. Risk:

1 2 3 4 5 6 7 8 9 10

Additional Comments:

Arrears on date of Outcome Monitoring Interview

(For Bromford service users this figure should be taken from Active H; for non-Bromford service users please use most recent figure from Landlord.)

Declaration

I, the undersigned, give Bromford Housing Group permission to enter this information into a database for monitoring purposes.

Print Name	
Signed	
Date	



Introduction

This outcome-monitoring model has been developed with the aid of Innovation and Good Practice Grant funding from the Housing Corporation to enable RSLs to monitor the progress of service users receiving support and to evaluate the success of the support provided in helping people develop their ability to live independently. It can be used in both fixed schemes and floating support services. It has been designed to suit the needs of a variety of client groups although it may need to be applied differently for some client groups. The model gives each new service user a score between 1 and 10 for each of nine areas of life skills. The score is then reviewed regularly with the service user to assess progress and recorded again when they move out.

The initial scoring could also be used to assess whether an applicant referred for a particular service has support needs that can be met there or whether they might be better served by an alternative service offering lower or higher support. In services where differential support costs apply it could be used jointly with the purchaser of the service to agree how many hours of support are needed for each individual.

During the pilot period our Support Workers have found that in most cases it is best to work through the model a few days after the service user has moved into a scheme or been signed up to a floating support service - unless it is done prior to moving in, as part of an assessment process. Although we initially aimed to do this when signing up new service users, workers found that service users felt overloaded with new information and issues at this stage and could not cope with going through the model then. It seems to work best when carried out at the service user's first keyworking session when it can be used to agree the support plan and prioritise areas to focus on.

The pack includes a description of all nine categories and a breakdown of the ten possible stages of the continuum. Also included is a recording sheet to record the responses.

The notes below are intended to show support workers how to apply the model in practice.

Guideline for completing outcome-monitoring model for supported housing service users / service users

The outcome-monitoring model should be completed at various intervals of the support process. These will normally be:

1. The sign up of the service user, or first keywork session
2. On a quarterly basis during key-working sessions,
3. On exit from the service

Some projects may decide to use the model as part of an assessment process before a service user moves in or is signed up.

The questions should be completed **with** the service user and not just from the worker's perspective. Similarly, the service user should not tick the boxes based solely on his / her opinions. The outcome-monitoring model is a joint tool that helps both service user and worker identify and track progress throughout their time with supported housing. The process of completing the forms should help the worker and service user get to know each other and form the basis for a relationship based on mutual respect and trust which is essential for effective keyworking.

Where there is a significant difference of opinion between the perceptions of the worker and of the service user, particularly when the initial assessment is completed, it may be necessary to involve a third party such as the service user's Social Worker or CPN or the agency who referred the service user to the supported housing service. Particular issues may arise where service users have mental health issues that affect their perception of themselves. Services may need to decide their own local approach to such cases, remembering that what matters is not the starting score but the progress made during the service user's time receiving support.

The guidelines are exactly that. There will often be times when a service user does not fit precisely into a single point on the continuum. In this instance, you should discuss the issue fully with the service user and agree to tick the box that seems most appropriate.

OUTCOME MONITORING

The Purpose:

The outcome-monitoring model has been designed in order to monitor the progress of service users receiving support from the supported housing team. **This includes Bromford and Non-Bromford service users.** Some floating support workers may be supporting service users in local authority or other RSL's these should also be included in the Outcome Monitoring process. It has been designed to suit the needs of a variety of service users although it may need to be applied differently for some client groups.

How Should it be done?:

- The model incorporates 9 categories each having a continuum of 10 responses. The complete outcome monitoring information pack includes a description of all 9 categories and a breakdown of the 10 possible stages of the continuum. Also included is a recording sheet to record the responses.
- ***The outcome-monitoring model should be completed at various intervals of the support process. These are:***
 4. The sign up of the service user. (If this is not possible, the model should be completed within the first few key-working sessions).
 5. On a quarterly basis during key-working sessions,
 6. On exit from the service.
- The Outcome monitoring questions should be completed **with** the service user and not just from the support workers perspective. Similarly, the service user should not tick the boxes based solely on his / her opinions. The outcome-monitoring model is a joint tool that helps both service user and support worker identify and track progress throughout contact with supported housing.
- Some service users may feel over whelmed with paperwork and the general support process. It may be necessary to complete the outcome monitoring model over a number of key working sessions. You should always seek further guidance from your line manager if this is applicable.
- The process of completing the outcome monitoring forms should help the support worker and service user get to know each other and form the basis for a support relationship based on mutual respect and trust which is essential for effective key working.
- The guidelines are exactly that. There may be times when a service user is unable to fit precisely into a category. In this instance, please tick the box that is most appropriate.
- Where there is a significant difference of opinion between the perceptions of the support worker and of the service user, particularly when the first questionnaire is completed, it may be necessary to involve a third party such as the service user's Social Worker, CPN or the agency who made the referral to the service. Particular issues may arise where service users have mental health issues that affect their perception of themselves. Individual services may need to decide their own local approach to such cases, remembering that what matters is not the starting score but the progress made during the service users time receiving support.

More Information:

The following references may give further guidance relating to this subject

Title	Location
Recording Responses form (the tick sheet that you should complete)	Appendix 17
The outcome monitoring model (information on the different categories)	K/Supported Housing/Policies/The Outcome Monitoring Model

Appendix 11

(Section taken from the Logic Model Handbook 2007)

Selecting Outcomes You Want to Measure

Pick the fewest number of outcomes that, as a group, will yield information for three key purposes ...

1. **Assure that you are achieving meaningful benefits for the intended beneficiaries** – Which outcomes are the most important for program participants to achieve? Which are central to the gains participants care about?
2. **Communicate the value of your program to key audiences** – Which outcomes do key audiences, including funders, care most about? Which resonate most strongly with your various stakeholders? Which best tell your story?
3. **Guide program managers and staff in increasing the effectiveness of your program** – Which outcomes will be the most helpful in identifying where the program is, or is not, being successful? Which will show what key links in the “if...then...” chain are working or are breaking down?

What are Indicators?

Indicators track a program's success on outcomes.

- ⌚ All of the indicators are **clearly linked** to and **measure progress** toward the associated outcome.
- ⌚ Each indicator is stated with a **target number and target percentage** of the total population that is expected to achieve the outcome.
- ⌚ All the indicators are based on the **target population**.
- ⌚ All the indicators are **observable** will **measure some aspect** of the outcomes they are attached to.

Outcomes & Associated Indicators

Outcomes are: Benefits for participants due to their involvement with a program.

Indicators are: The specific information collected to track a program's success on outcomes.

Examples:

Outcome: Participating students succeed in school.

Indicator 1: 70 of the participating students (78%) will pass all their core subjects.

Indicator 2: 60 of the participating students (67%) will advance to the next grade level.

Outcome: Job training graduates become gainfully employed.

Indicator 1: 52 of the graduates (69%) will secure full-time employment.

Indicator2: 40 of the employed graduates (77%) will remain employed for at least 6 months.

Outcome: Parents read to their preschoolers more often

Indicator: 280 parents (80%) will read to their preschoolers everyday for a minimum of 30 minutes per day during the Fall 2007 semester. 25

Advanced Training Developing Indicators

Effective Indicators are SMART

- 🕒 Specific
- 🕒 Measurable
- 🕒 Attainable
- 🕒 Relevant
- 🕒 Time-bound

Common Misconstructions when Writing Indicators

• Vague Indicators

- Job Promotions
- **Can be written as:** 50 clients (64%) will receive job promotions within 3-months of completing the course.

• Not Written Measurably

- Able to converse better
- **Can be written as:** 42 ESL graduates (91%) will demonstrate improved English language conversation skills based on pre/post testing.

• Listing Measurement Documents

- Attendance Forms
- **Can be written as:** 33 students (67%) will have perfect attendance during the Fall 2007 semester.

• Listing Measurement Plans

- Review of Test Scores
- **Can be written as:** 75 students (85%) will pass all of their core subject final exams.

• Listing Outputs or Strategies (process-focused)

- Clients attend all 10 workshops
- **Can be written as:** 45 clients (74%) who attended all 10 work shops will demonstrate improved credit score ratings.
- Six trainings are offered during the year

o **Can be written as:** 123 training participants (90%) will show increased knowledge of the subject based on pre/post testing.

• **Listing Outcomes**

o Clients change behaviors and make healthier choices

o **Can be written as:** 58 clients (89%) show improved nutritional intake at the 3-month re-assessment

• **Not Associated to Outcome**

o Homework assignment completed (for measuring self confidence)

o **Can be written as:** 12 students (72%) who complete the leadership training course will self-report improved self-confidence.

Valley of the Sun, United Way (2007) *Logic Model Handbook*

http://www.vsuw.org/site/DocServer/Logic_Model_Handbook_Updated_2007.pdf?docID=801

Appendix 12 – Outcomes Star

Outcomes Star

Project Name: _____

Client Name: _____

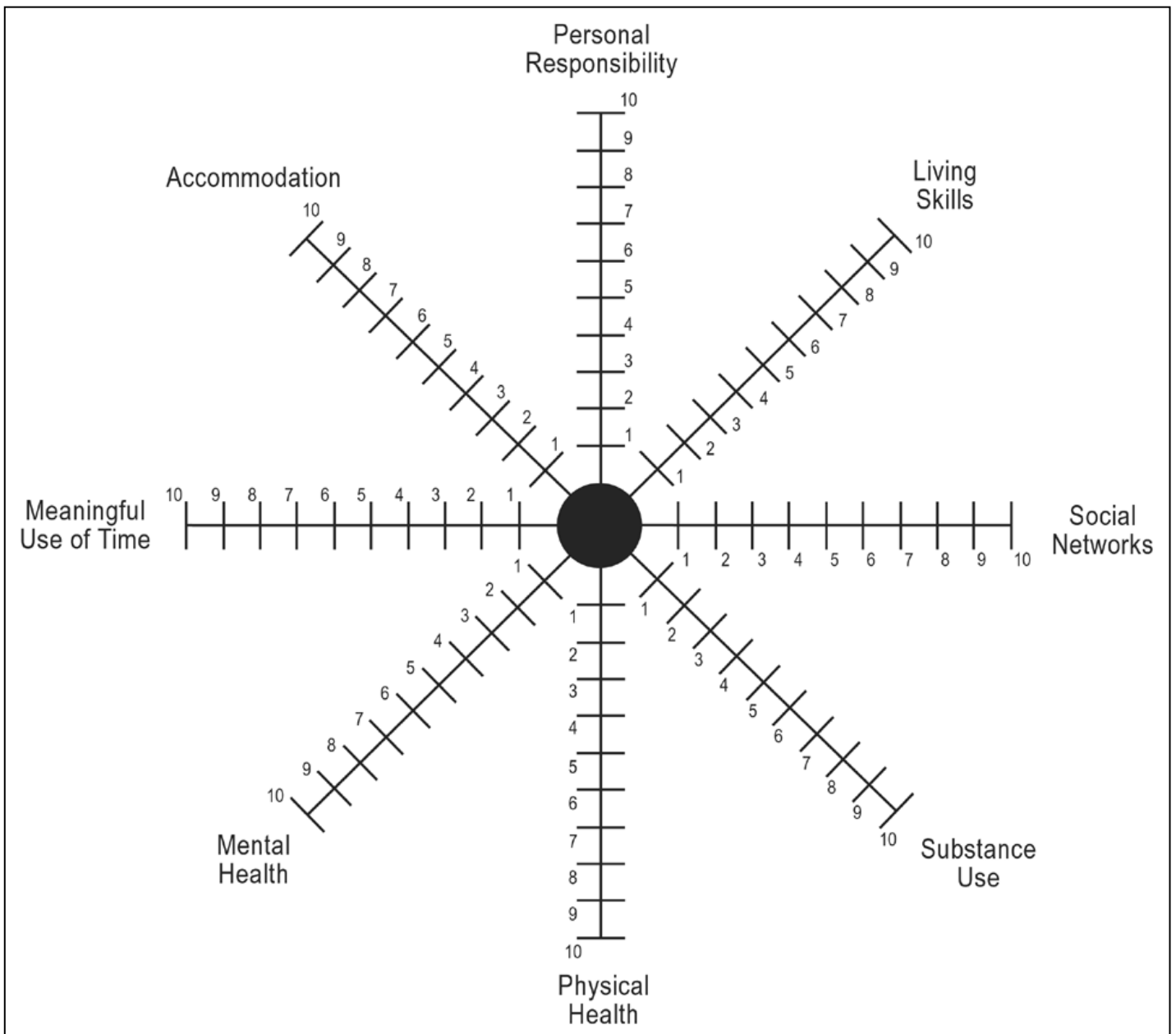
Date: _____ Review (1st/ 2nd etc.) _____

Worker Name: _____

Completed by: Worker and Client Jointly

Worker only

Client only



Scales for the Measurement of Soft Outcomes

Performance Support Unit
November 2004

1. Personal responsibility/motivation/self worth

This is the only scale that measures an inner core of change. It is at the heart of the changes described and measured by the other scales, which can be viewed as external manifestations of an inner change or maturity.

No.	Indicators
1	There is a lack of motivation to change. May take little or no responsibility for circumstances and see no reason for wanting to make changes.
2	There is the first sign of wanting to change and some insight into the possibility of change. First signs of not being comfortable with things as they are. Sometimes the worker will note this before the client has become aware of it.
3	Start talking about wanting to change but there is a feeling that it is too difficult. At this point may start to make appointments and commit to things but will find it hard to stick to arrangements or will make excuses as to why things don't get done.
4	Start to request help and will go along with the help that is offered. This is a time of uncertainty about what is wanted and it can prove hard to take charge of life. May need encouragement to be fully involved in the process.
5	The client is beginning to know what they want. May start to look at problems as temporary and will start to talk about goals and how to go about achieving them.
6	Development of a real sense of purpose, but needing a lot of support. Actively engaged with the support needed to move on. Old lifestyle may still be hard to give up completely.
7	Growing sense of being able to make choices. Greater insight into the link between certain behaviours and their consequences. Feeling more in control.
8	Noticeable change in behaviour over a period of time. Characterised by getting used to weighing up different options and making choices with confidence.
9	Increased comfort with new lifestyle or way of being. Clear of own role in building and maintaining what is wanted out of life and of how to access any support needed. Occasional hiccoughs.
10	Taking responsibility for maintaining and developing self. Confident in new lifestyle. Sense of connection. Own support network as needed.

2. Living skills

Note: Type of accommodation and readiness to move on are recorded separately.

No.	Indicators
1	May be unable to look after basic needs such as keeping warm, safe, clean and fed. May be street homeless, at risk of losing tenancy, not coping at home etc
2	There is an awareness of basic needs but these are being met in a haphazard way, for example finding places to eat or sleep on a day to day basis.
3	Acceptance of help with (or has already) registering for benefits but will need help to keep claim running. May still not be managing well with living skills like cooking, budgeting, having a hygienic living space and personal hygiene.
4	Starting to carry out some tasks such as using laundry facilities or some improvement in personal hygiene. May engage with help (i.e. lifeskills worker) if offered but not actively seeking help.
5	Want to be able to carry out certain tasks and life skills start to appear as goals on Action Plan. May see improvements such as buying food in, money going further, improved hygiene etc.
6	Using some living skills routinely, at this point there might be the odd exception with areas that still need to be worked on. Things may still go wrong, for example not dealing with warning letters, benefit changes or keeping things going during times of stress.
7	Pretty good standard in most if not all areas of hygiene and appearance, shopping, cooking basic meals, budgeting, managing benefits, dealing with bills, accessing services and acting to prevent crisis.
8	Generally capable, with the living skills to live independently with a low risk of the tenancy / placement breaking down. More forward thinking and plans exist to avoid future problems. May still need ongoing support in some areas, particularly with financial issues.
9	Increasingly fully independent and able to share skills with others, for example helping others to cook and shop.
10	Fully able to live independently, with the necessary skills and able to draw on external resources as needed.

3. Social networks

Key to scale: transfer of allegiance from “street” to more positive social networks. From manipulative / exploitative to genuine relationships. Having said this we need to acknowledge that many clients value their street community and may have found a source of support there.

No.	Indicators
1	No meaningful positive social network. May be completely isolated or may associate exclusively with street or drug community in a negative way (relationships are exploitative or lacking in trust and mutual regard).
2	A growing awareness that there may be harmful or negative aspects to current friendships / relationships, or a growing desire to end isolation
3	May engage with people outside immediate peer group but without trust / respect / mutual regard. First steps of engaging with staff / volunteers / new peers but may be cautiously. There may be an element of ‘testing’ new contacts to see if they can be trusted.
4	May start to engage in activities available in accommodation. May start to recognise when being exploited by others but still finding it difficult to avoid negative or to seek positive contact.
5	May start to establish positive relationships and address relationships in life. May start to value and trust relationship with keyworker (and other staff), there might also be issues around over-reliance on the keyworker.
6	May be in between peer groups – moving away from the harmful relationships but still tentative in building new relationships. May need support in recognising constructive relationships. May be thinking about the nature of their family relationships for the first time in a while. Those who are naturally private may still be, but are less hostile and more able to express their desire for privacy in a way that is understood.
7	Greater ability to trust and relate to others. Relating in a way that is stable and trusting. Recognising the destructive effect of some previous relationships with friends and / or family. May be making first steps to contact family / old associates if this is possible and positive.
8	Actively building positive relationships with friends and/or family at a level appropriate to the client. More aware of external issues. May have contact with previous peers but more time spent in constructive relationships. May be helping old associates to change themselves.
9	Generally engaged in constructive and positive relationships. Willing to explore and take risks to get to know people if this is appropriate to the client. Loose / occasional / constructive contact with previous peer group. Real examination of previous relationships now possible within supportive framework.
10	Now feeling fulfilled by contact with others at whatever level feels comfortable for them. (If appropriate - Resolved any major issues with family).

4. Substance use/risk taking

Note: If drug/alcohol misuse is suspected but not confirmed over a long period of time, the client will stay at a "1". If they are then found not to have a substance misuse issue (e.g. behaviour was actually around mental health or other issue), they would then go straight to scoring "10"

No.	Indicators
1	Little or no insight into substance use and consequences. High and chronic levels of drug and alcohol use with poor i/v practises increasing risk of infection and of trauma. Associated behaviours may include greater contact with the Criminal Justice System or deterioration in physical or mental health.
2	Some harm reduction measures in place – for example accessing needle exchange, considering information about services and the effects of Substance Use and possibly beginning to engage informally with staff.
3	Growing insight into drug or alcohol use and associated harm. More informal engagement but not working well with appointment system. No reduction in drug or alcohol use at this stage.
4	More formal approach but inconsistent engagement with services and still undecided about treatment options. May engage with scripting services (but may use on top), Primary Health Care Services, taking vitamin supplements etc
5	Increased awareness around consequences of drug and alcohol use. Initial reduction in use however may not actually change use substantially, but less chaotic, more confident and/or more motivated and committed to make changes. May be succeeding in use of script
6	Reducing alcohol use; changing drinking patterns, low strength alcoholic drinks: reduction of use on top of script; accessing more in-depth support. May see an improvement in physical appearance. SU still impacting on relationships, health and life skills but to a lesser extent.
7	Beginning to explore triggers: may have 'dry' days or periods of time of not using on top of script. Reduction in criminal activity: engagement in appointment system. Put back in increased confidence. Script reduction, attending Key Work sessions, may attend groups or drop-ins. Looking at referral to treatment such as detox or rehab. Possible binge drinking.
8	Showing much greater control and actively avoiding high-risk situations. Longer 'dry' / 'clean' periods; moderate substance use. Greater engagement with support services: improvement in appearance and health; controlled drinking.
9	Motivated and more confident; willing engagement in re-training programmes and meaningful activities; possible 'lapses' but with enhanced coping strategies in place
10	No illegal drug use. Abstinent or moderate alcohol use. Effective relapse prevention strategies in place

5. Managing physical health

Note: This scale is about how clients take care of themselves and their health – as this can change. It is not about actual improvements in health, as these are dependent on so many other factors.

No.	Indicators
1	Not taking any responsibility for own health. May self-neglect to the point of self-harm.
2	Some suggestion of wanting to change such as thinking about registering with GP or allowing a medical professional to visit.
3	Let workers know when they have an acute health problem (e.g. ulcers) and accept help with addressing the immediate problem. However, problems that are less severe / obvious are ignored, don't feel they can do much about them. May register with GP if accompanied.
4	Accept help via GP or internal health services as needed. Complying with treatment but still reliant on staff or friends to encourage and facilitate this.
5	Motivated to be more healthy, e.g. showing greater responsibility for attending appointments and talking about health more constructively.
6	Can make the link between their medication, therapy or other treatment and keeping out of hospital/ prevention of worse harm. Engaged with treatment plan but still need a lot of support.
7	Awareness of choices or actions that are positive for own health. Managing existing physical problems appropriately. May report feeling physically healthier.
8	Active concern for own health and taking actions to improve health. May change diet or exercise, smoking etc.
9	Is able to report feeling as well/ healthy as they have ever done. Levels of self-awareness around health allow for avoidance of crisis.
10	Independent and responsible approach to own physical health: reasonable self care (diet/ exercise), comply with existing treatment, and able and willing to access help if needed.

6. Managing Mental Health

No.	Indicators
1	Not taking any responsibility for mental health. Belief that symptoms are beyond control. Symptoms may lead to severe distress and impact negatively on activities of daily living. No input from services excepting statutory interventions.
2	Some avoidance of high-risk situations, i.e. substance use; may lead to a slight reduction in crisis. First glimmer of wanting things to change such as allowing MH assessment or presenting to services when in crisis.
3	Growing recognition that there is a problem and that action can be taken to make things better. However, feelings of powerlessness and helplessness still dominate and it may be hard to see how to change. Likely to make, and then miss appointments. May miss meds or depot without substantial prompting.
4	Early stages of allowing help. Some willingness to explore issues with an early belief that it is possible to manage illness / lessen the impact of symptoms / reduce the frequency of relapse. Still tending towards being passive in the treatment of illness.
5	Increasing awareness of being able to influence the impact of mental ill health. Acceptance of areas of vulnerability and starting to identify ways of avoiding triggers for relapse. More positive engagement with services; may start using day centre, seek out MH worker etc. Start of commitment to change.
6	Self-esteem / satisfaction with life may fluctuate but there is a general feeling that quality of life has improved. Engaged with services, and early stages of looking at learning coping mechanisms and adopting a relapse prevention plan. Actively self-medicating. Still need a fair amount of support.
7	Growing sense of being able to make choices. Aware of and actively avoiding triggers for relapse. Identifying and using coping mechanisms. Relapse prevention plan, if required, is in place.
8	May report feeling as in control as ever before. Symptoms may very well persist but there is a sense that life goes on despite symptoms rather than life being dictated by them. Can weigh up options and make choices with confidence.
9	Comfortable with lifestyle and ways of coping. Full responsibility for maintenance of emotional and mental health. Able to access services and support as and when required. A responsible attitude to risk taking may be possible, (i.e. critical viewpoint on medication). Socially active within bounds of ability / inclination.
10	Full responsibility for maintaining and developing emotional and mental health. Confident in new lifestyle. Own support network in place. Independent of St Mungo's.

7. Meaningful use of time

No.	Indicators
1	There is a lack of motivation or confidence to engage in meaningful activity. Avoidance of social situations or structured leisure activities.
2	May start to spend some time in a meaningful way, for example choosing to sit with others if only for a short time.
3	Starting to express dissatisfaction with current ways of spending time. May start to make appointments / arrangements but not ready to follow through with the commitment. Will find there are excuses for dropping out at the last minute.
4	Starting to follow through with some arrangements / appointments. Peers and professionals may still have to do a lot of supporting and persuading. Likely to start to engage with 'in-house' activities. Many will start to express dissatisfaction with what is 'on offer' in an early attempt to explore their goals.
5	Want to change situation. Start to have an idea of where they might want to head and start to show commitment to making changes. Considering training / activities etc in more concrete way.
6	Clearer sense of what they would like to do and some of the steps needed to get there. Participate actively. Attending appointments more regularly. Able to set and meet short-term goals. A difficult time where support is needed and there may be many set-backs..
7	Noticeable change in behaviour. Can evaluate different options and make choices. Actively engaged in some structured meaningful activity.
8	Active in getting closer to goals. Aware of how they are seen by others. May dress appropriately for interview, write CV, committed to voluntary work, training, placement, job-search or other steps along the way to their longer-term goals
9	More comfortable with new lifestyle or ways of being. May run into occasional difficulties or need some low-level support.
10	A feeling of being in the right situation / place for the foreseeable future - whether this be paid work, voluntary work, in education/ training, or have a structured daily routine which satisfies and challenges.

8. Accommodation

Note: The actual accommodation or project will be noted separately. This scale is about how clients manage or relate to their accommodation.

No.	Indicators
1	Finding it hard to live within the constraints of their environment (rules/culture/tenancy agreement), and no motivation to address this. Not regularly seen by staff and not engaging with services.
2	Some increasing awareness that addressing challenges/issues will help to retain accommodation and dictate the progress of resettlement. Accepting help to get Benefit claim up and running.
3	An increased commitment to making changes to lifestyle in the areas that allow for a move to more permanent or more appropriate accommodation, or to retain existing accommodation (budgeting, hygiene, less chaotic lifestyle etc). May not always keep to agreed arrangements/appointments.
4	Starting to request help and go along with help offered with issues that arise in accommodation. Aware of consequences (regarding moving on or keeping accommodation) if not resolved/addressed.
5	Working towards fulfilling the criteria to retain accommodation or to move on. Starting to pay off arrears or address issues which could have effect on tenancy, with support from staff.
6	There is a commitment to maintaining accommodation, accepting support as needed in order to do this. Sometimes omits to request help when needed.
7	Accommodation is working well with the input of support. There may be occasional problems with rent arrears / benefits / living with neighbours etc.
8	Developing interests/contacts in local community (or in project) and attending regularly without input from staff.
9	Very low risk of loss of tenancy and support networks in place. Able to request support at appropriate time when needed.
10	Able to manage all aspects of tenancy, with own support network as needed.

St Mungo's

Guidance Notes for use of the Outcomes Star.

Background.

The star has been developed as a way of measuring changes in our clients. It is designed as a client focused system, capable of tracking a person's movement through St Mungo's.

How will it help you as a Key Worker?

It can be used as a tool for addressing particular areas of a client's needs. Also, because it is happening at regular, but spaced, intervals, it allows you and the client to see what progress you really have made, despite day to day change sometimes seeming minimal.

It is hoped that key workers, specialists and managers will find the information from this system exciting – showing who is changing and how.

Will it help Managers aswell?

It will offer managers scope for exploring how to do things even more effectively.

How is the form completed?

- The star has 8 dimensions, each on a scale of 1-10. The guidelines for each number on the scale are attached.
- They are designed on the basis of whole numbers - do not use points or fractions.
- It is likely that projects working with more chaotic clients will be using the lower numbers on each scale, and those with more settled ones the larger numbers, i.e. a client going from street to independent home would, in theory, move from 1 or 2 to 9 or 10.
- In order to make their assessment, the key worker will draw on information from information from all workers involved with the client, which is contained in the single file and on Map IT.
- Tie the Star in with the Action Plan and your key working. Keep a record in the progress notes any comments the client has made about the Star, areas where you have agreed or disagreed. Also keep a record of the points you discussed.

Who should complete it?

- The key worker and the client should complete the Star together, wherever possible.
- If the worker and the client come up with differing answers, you should try to seek agreement through discussion.
- If this isn't possible, this should be recorded. For example, two Stars should be recorded. It would also be a good idea to record on the file any comments the client has made.
- The key worker will be responsible for completing the star with the client, as this does require a consistent and reasonably trusting relationship to do well. The Key Worker is responsible for ensuring the Star is completed at the appropriate time.

Involving your Clients.

- Tell the client about the Outcomes Star when they first book in. Let them know where they can find out more about it (from other residents, notice board, resident reps., key worker).

- Always introduce the Star to your client before you arrange to complete it, and ensure they understand it. Give them a copy of the Star & Scales to take away with them and look at. This way, the client is more likely to take ownership of it, and the Star will be will more meaningful.
- Ask them for feedback, either through residents' meetings, one to one sessions, etc.
- If they want to get more involved, e.g. in forming a residents' group, contact Andy Williams, User Involvement Co-Ordinator, at Rockley Road, 0208 600 3030.
- Give your client a copy of the completed star to keep. Compare it to previous Stars, so that you can see any change & focus on different points as a tool for key working.

How will the Star help clients?

The star is designed to support key working. Each scale is based on the outcomes St Mungo's aims to achieve and the indicators we need to report on. It is designed primarily as a measurement scale, but one that can be used constructively with clients. The Star is a visual form – when you complete the second reading you and the client will see an immediate visual message – the Star may have changed shape, got bigger, developed in some areas and not others.

When should it be completed? How often?

The aim of this tool is to measure change – thus the earlier you take a reading with the client the greater (in theory) the change will be. However, it takes time for a relationship to develop and for someone to be realistic about themselves (taken into account by the scores 1 and 2 which have the client out of touch with themselves and others).

- At Endsleigh Gardens, during the initial pilot in 2003, they decided to take the first reading at six weeks, followed by one at three months and then quarterly. They have chosen this frequency as their clients move on rapidly, and it fits with their own key working rhythms.
- Semi-Independent Housing, however, have less contact and more stable clients – they will complete the first reading at around two weeks, and then every 3 or six months, reflecting the slower rate of change.
- The key worker can keep a paper copy for themselves and the client so that they can see progress alongside the computer system.

What is Map IT?

This is the name for the computer system being developed. It is a web-based database, extending Solstice, to include the Star and all elements of Joint Action Planning. Managers and workers will be able to run outcome reports for individuals and for their project as a whole.

June 2005.

For more Information, please contact Maxine Jordan, Action Planning Co-Ordinator. 0208 600 3008.

Using the Outcomes Star

Developed for the London Housing Foundation by Sara Burns,
Kate Graham and Joy MacKeith of Triangle Consulting.

A one-day training course

The Outcomes Star Collection [Using the Outcomes Star - a One-Day Training Course](#)
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For the full document, please visit:

<http://www.lhf.org.uk/Publications/OutcomesStarTraining.pdf>

Appendix 14 – Measuring Outcomes, How can we do it? Lancashire County Council

<http://www.ic.nhs.uk/our-services/improving-social-care-information/adult-social-care-information-development/adult-care-information-network/measuring-outcomes-for-service-users>

Measuring Outcomes. How can we do it?

What we've done in preparation for this

We have been conducting a number of experiments in measuring outcomes. Some have been successful, some not, some are continuing. These experiments include:

Older People – asking specific questions in reviews relating to service perceptions and checking if perceptions matched qualitative PIs (44 people interviewed as part of reviews).

Learning Disability – matching actual achievements in reviews to specific outcomes identified in Care Plans (80 service users involved in this during service reviews. Providers involved).

Physical Disability – A questionnaire on service user perceptions was administered by contract monitoring officers (80 service users. Such questions are now asked as a matter of course by one group of contract monitoring officers)

Physical Disability – A project matching objective achievements against specific outcomes identified in care plans is about to begin. (this envisages a two stage approach to identifying outcomes for PD people with long term needs, the first to identify general outcomes and the second after detailed work with the provider is to identify specific outcomes, subject then to review. The pilot will probably involve 20 people)

Substance Misuse – six monthly Quality of Life self perception questionnaire administered by social workers as part of the review process. (this process involves all service users subject to a rehab programme and follow up – 200 at any one time?)

Carers – A set of self perception questions administered by contract monitoring officers. (Started in Sept 06, 12 carers interviews so far, fits in seamlessly with the work of the contract monitoring officer).

Other work being discussed includes:

Mental Health – discussions are underway about using 'Discovery Interviews' with a number of service users

Supporting People – A new set of outcome measures has just been published

Older People – finance assessment staff could be asked to collect data about the perception of service users.

There is a working group developing outcome based commissioning. This is being led by Janet Beadle.

Dom and Res Care service users – the feedback arrangements envisaged in response to the CSCI document *Inspecting for Better Lives* could include questions specifically matched to the seven outcomes.

In addition all internal surveys undertaken now within the Directorate have their questions mapped to the seven outcomes.

Aligning the audit programme to ensure data collected can be collated under one or more of the seven outcomes.

Ensuring intelligence from complaints and compliments can be collated against the seven outcomes.

What have we learned from this work?

We have learned that

- face to face questioning of service users is labour intensive in some circumstances (ie reviews). Seeking perceptions from service users in relation to the seven outcomes could only be done regularly on a sample basis

- Face to face questioning can be incorporated into the work of contract monitoring officers quite easily.
- There are three sorts of 'outcome' information we need to collect.
- SU perception information,
- information about the outcomes of care plans,
- and the overall impact of our services on overall SU populations.
- Care Plans are currently not that outcome focussed – making the checking of outcomes at review time difficult.
- There are several ways of working smartly on this, by using as many occasions for this purpose as there are when staff are in touch with service users and their carers and by asking providers to seek feedback from service users.

Getting on with it.

I am not entirely clear how we can prepare for the outcome aspects of the new PAF. It may be that new 'outcome' PIs are required in which preparation in the wrong direction would not be helpful. On the other hand if the requirement initially is about our ability to collect, collate and use evidence of good outcomes from service users we are in a good position.

We need to get on with something so what about:

1. Brief all staff about working to outcomes. All staff must think in outcome terms – 'what will be the outcome of this service?' (providers too and all staff, not just CCOs, SWS and RASOs).
2. All info we seek and gain from SUs has to matchable to the outcomes (review activity, complaints, surveys, questions and discussions in user forums, service audits, contract monitoring). We should devise a set of questions to be used wherever we are in contact with SUs which can be tracked back to the seven outcomes. These should be for use across the board in ALL our contacts with service users and opportunities for user and carer feedback.
3. In addition all this material has to be made available on a platform where it can be considered for commissioning, service development purposes and possibly performance purposes. So how do we collate material for different sources, how do we store it, how do we report it, how do we use it? How do we resource it all?
4. Care Plans and reviews MUST be outcome focussed (can we involve providers in this?)
5. Decide whether we need to amend ISSIS to more properly capture info about the outcomes in care plans and reviews. Do we need a system enhancement?
6. Each service should be asked to outline what they do now and what they intend to do to ensure relevant outcome evidence is available about their services.

I'm committed to getting back to SMT within a month outlining what it is we should be doing to prepare, so I need a bit of help to sort this out.

Dave Burnham
4th October 2006

APPENDIX

What does 'Outcomes' mean?

This is not defined and the starting point is that the outcome is focussed on the impact on the service user – rather than the output or process completed by the social care or health organisation.

The definition of outcome we are using is: *the impact of the service on the attitude, ability, confidence, perception or capacity of the person receiving the service as a result, wholly or partly, of that service, whether planned or not.*

The outcome of a service can be positive or negative.

We seek to help the service user to achieve planned and positive outcomes.

Outcomes are not the only measures of success for social care organisations, but need to be incorporated into the pattern of measures which currently include.

- Business Processes. (ie timeliness of assessments completed) Efficient processes are the bedrock of any organisation
- Outputs. We need to know the numbers of different types of service delivered.
- Finance. Any organisation has to operate within the financial capacity of the organisation.
- Innovation. Unless successful implementation of innovatory ideas is measured there would be little change or development of services.

People served by health and social care fall into four broad categories.

- Maintenance. Those people who have long-term enduring conditions which lead them to be dependent for daily living on some form of care support
- Rehabilitation. Those people who have conditions, which though long-term, with the right type of enablement/ rehabilitation the amount of long-term support required can change and reduce over time.
- Short term. Those people who have shorter-term conditions, which with the right type of enablement/rehabilitation will need little or no care support.
- One off. Those people who have minimum care needs that may be helped by sign posting to community based services.

The outcomes planned for positive outcomes for people in such different circumstances will be different. In broad terms they will either be:

- Maintenance outcomes (e.g. to enable someone to continue living at home despite failing health)
- Change outcomes (e.g. where people experience improvements in the quality of their life that leads to greater community involvement and less dependency on social care services)
- Completion outcomes (e.g. where someone wanted some information and they received it quickly and accurately)

There are in general terms three ways of seeking evidence of positive, planned outcomes:

Seeking the service user's perception of the quality of the service, its effectiveness or its impact on them. These perceptions can be gained from postal surveys, by telephone, face to face during reviews or monitoring exercises, or by using more sophisticated tools such as Discovery Interviews. Self perception is powerful and direct – but it is not objective. It may be prey to the nervousness of service users that their service might be taken away if they say the wrong thing, subject to mood, a response to the demeanour of the 'interviewer' and so on.

(Of course, some of the OHOCOS outcomes rely overwhelmingly on self perception.

Whether someone feels harassed or feels they have been treated with dignity or respect is not something that can be gauged other than by self perception).

Checking individual achievement against a planned outcome. This can be followed if an outcome is planned for, recorded in a care plan, and work undertaken to achieve the outcome. The service review is the most obvious occasion for a review of the 'objective' achievement of the outcome.

Checking a population's achievement against a general outcome for the population. If a goal in relation to the outcome 'making a positive contribution' is, say, an increase in the number of people with a learning disability registered to, vote progress against this outcome can be

checked by surveying the population's achievement. This sort of data may be available from national sources or may require local surveys of given populations.

Possible Problems

1. One of the key problems here, especially in relation to the impact of grant funded services (non direct services) which may have a minor impact on a person's life is how can we be sure that the improved quality of life or perception of being treated with dignity is 'attributable' to the service we have made available?
2. if we are collecting self perception data we need to be aware that we should seek perceptions at an appropriate time for each type of person. There is not much point in asking the person who has been in receipt of a home care service for five years what difference it has made in their quality of life, or the person who has only had a service for a week about it's impact on their life.
3. Any face to face activity or review activity requiring detailed consideration of whether a detailed care plan has fulfilled its purpose is likely to be more resource hungry than current processes.

Appendix 15 – Assessment Paperwork

NORTH LANARKSHIRE

SOCIAL HISTORY

Analysis of Need Information should include the person's family background providing details about the person's position within the family. Relationships with family members, relationship with partner, relationship with own children, relationship with extended family and relationships friends and neighbours. Also include information on current or last occupation, work history, education and relevant life experiences

Text...

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COMMUNICATION	Yes	No	Not Considered

This section will consider all forms of communication

Analysis of Need The person should be central to the process of assessment and to do this it is essential to understand and record how they communicate. You have already noted the person's preferred language, and whether there is a need for interpreter or sign language service. This section should contain more detailed information about the person's communication style. This section should contain information on how the person expresses views, understands spoken and written language and listens to others. You should also note particularly how the person manages in their home, in social settings, in more formal situations, how they use the telephone, use emergency call systems if in place. You should consider how the person recognises family, close friends, other key people and support providers. You should pay particular attention to any sensory impairment and the impact on communication..

	No Need	Need	Need Met	Not Considered
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facilitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Text...

Outcome Improved Communication/Sustaining social contact and company/Valued and Included

Text.....

FINANCE Yes No Not Considered

Analysis of need The section should include current income and savings. Details of benefits claimed should also be recorded along with a completed FA1. Remember that service users are expected to make a contribution to the cost of their package if support is required and should be advised of this potential.

	No Need	Need	Need Met	Not considered
Income Maximisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Text...

Outcome Economic Wellbeing

PERSONAL CARE Yes No Not Considered

Analysis of need This section covers all aspects of personal care including washing, dressing, toileting, nail care, hair care, skin care, shaving and applying make-up..

	No Need	Need	Need Met	Not Considered
Balance and falls risks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Is the person able to wash his/her hands and face?

- A Without Difficulty
- B Without difficulty using equipment or an adaptation
- C Has difficulty even when using equipment or an adaptation
- D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

Is the person able to give himself / herself a complete wash, a bath or a shower?

A Without difficulty

B Without difficulty using equipment or an adaptation

C Has difficulty even when using equipment or an adaptation

D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

Is the person able to wash his / her own hair?

A Without difficulty

B Without difficulty using equipment or an adaptation

C Has difficulty even when using equipment or an adaptation

D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

No Need Need Need Met Not Considered

Nail/skin care

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Dress/undress

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Is the person able to dress / undress himself / herself?

A Without difficulty

B Without difficulty using equipment or an adaptation

C Has difficulty even when using equipment or an adaptation

D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

No Need Need Need Met Not Considered

Toilet Use

ADL Score

- A** Is independent
- B** Is independent with catheter or colostomy and equipment or adaptations
- C** Needs assistance
- D** Requires encouragement, prompting or supervision
- E** Requires complete assistance
- F** Does not use the toilet

No Need Need Need Met Not Considered

Eating a meal

When eating a meal, the person ...

- A** Eats without assistance
- B** Eats without assistance using equipment
- C** Eats with help, e.g., cutting up or puréeing food
- D** Eats with encouragement, prompting or supervision
- E** Requires complete assistance
- F** Receives nutrition by tube or infusion

No Need Need Need Met Not considered

Food and drink preparation

Is the person able to prepare, cook and serve himself / herself a main meal?

- A** Without difficulty
- B** Without difficulty using equipment or an adaptation
- C** Has difficulty even when using equipment or an adaptation
- D** Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

Is the person able to prepare himself / herself a light snack (e.g. sandwich)?

A Without difficulty

B Without difficulty using equipment or an adaptation

C Has difficulty even when using equipment or an adaptation

D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

Is the person able to prepare himself / herself a hot drink (e.g. cup of tea)

A Without difficulty

B Without difficulty using equipment or an adaptation

C Has difficulty even when using equipment or an adaptation

D Requires prompting, guidance, supervision or encouragement

E Cannot do without assistance from others

No Need Need Need Met Not Considered

Nutrition and Diet

Text...

Outcome Keeping Clean and comfortable

Text

COMMUNITY LIVING Yes No Not Considered

Analysis of Need This section will cover 6 main areas but can be used to detail any other issues not identified below. Relationships and Family Networks not covered in social history. Can the person make new friends and maintain friendships? Spiritual, religious and cultural matters ' you should note any issues relating to ethnicity and culture, worship or other religious observations. Note any specific requirements in relation to diet and care arrangements when accessing community facilities. Transport and Getting Around ' How does the person manage public and private transport? Can they get in and out of the car? Does the person manage to use a bus, train, taxi, and aeroplane, how far can they walk outdoors? Employment ' If the person is in employment please note if this is full time, part time or voluntary. Are they retired, unemployed or have they never been employed? If they are retired or employed ' please note the detail of when.

	No Need	Need	Need Met	Not Considered
Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual/Religious and cultural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships and family networks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport and getting around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social and Recreational issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Text...

Outcome Enjoying and Achieving; Making a Positive Contribution; Respected and Responsible

Text

HOME AND DOMESTIC ENVIRONMENT Yes No Not Considered

Analysis of Need. This section includes how the person manages the environment both within their home and immediate locality and impact this has on their quality of life. Consider advantages/disadvantages of adaptations or alternative solutions. You should record how the person manages their home environment and note any assistance in place or required. Consideration should be given to housework, laundry, cooking, heating, lighting and home security. Also note how the person manages home appliances both gas and electrical, how they managed telephone bills, mail and finances generally. Are there any pets in the house, does their care present any difficulty? Record any potential hazards or difficulties in relation to the different areas of the home, including the lounge, kitchen, dining area, access to the house. Household composition ' comment on whom the person lives with and note any dependent adults or children.

	No Need	Need	Need Met	Not Considered
House care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintaining a secure home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety with appliances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to manage in home environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing money and finance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Text...

Outcome Enjoying a clean and orderly environment

Text

PHYSICAL HEALTH AND MOBILITY Yes No Not Considered

Analysis of Need This section should cover the person's physical health, stability of health needs, medication and health improvement. Please provide details of any medical conditions and treatments and their affect on independent living. The following areas should be considered specifically: Eyesight, hearing, speech, continence, bowel management, breathing, diet, swallowing, dental care, pain management, allergies, sleep, skin care, epilepsy (including type, precipitating factors, frequency, affect on life, medication). Provide detail of any adaptations or equipment in place to assist the person. Any hospital admissions over the past 12 months should also be noted.

	No Need	Need	Need Met	Not Considered
Health needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mobility

When transferring from bed to a chair or wheelchair, the person ...

- A** Transfers independently
- B** Transfers independently using equipment or adaptations
- C** Needs the assistance of one person
- D** Requires the encouragement, prompting or supervision of one person
- E** Needs the assistance of more than one person (with or without equipment)
- F** Does not transfer from bed to chair (e.g., confined to bed, etc.)

No Need Need Need Met Not Considered

Medication

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Bowel Management (IORN 12)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

Does the person require any of the following interventions or treatments relating to bowel Management?

Provision of assistance, guidance, prompting or supervision to maintain bowel functions

- A** Never or less than once a week, on average
- B** More than once a week, on average

Text...

Outcome **Being healthy/keeping active and alert**

Text

MENTAL HEALTH Yes No Not Considered

Analysis of Need. Record any general observation on mood, affect, and motivation as well as any specific mental health condition. Provide information on the condition, how long have they had it, how it has affected the person. Does the condition require treatment, how often, and who provides it? How does the person feel about their health, do they understand it, are they aware of it?

	No Need	Need	Need Met	Not Considered
Problems with memory, understanding and orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression and anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has the person exhibited any of the following behaviours in the last four weeks? (Please tick one box for each behaviour, the scores for the questions are simply the value of the box ticked, either 1 or 2.)

A. Agitation/Restlessness

Is the person agitated or restless?

- 1 Twice or less in the last four weeks
- 2 Three times or more in the last four weeks

B. Disturbance/Disruption

Has the person disturbed or disrupted other people?

- 1 Twice or less in the last four weeks
- 2 Three times or more in the last four weeks

C. Verbal aggression

Is the person verbally aggressive?

- 1 Twice or less in the last four weeks
- 2 Three times or more in the last four weeks

D. Resistiveness

Is the person unco-operative or resistant to help with their care?

- 1 No
- 2 Yes

E. Relationships

Has the person had difficulty with key relationships?

- 1 No
- 2 Yes

F. Risk

Has the person's behaviour constituted a risk of harm to themselves or to others?

- 1 No
- 2 Yes

Text...

Outcome. **_Improving wellbeing; Confidence and / or Morale: Regaining skills level**

capacity

Text

DRUG AND ALCOHOL DEPENDENCY Yes No Not Considered

Analysis of Need. If drug and/or alcohol use has a significant impact on daily living, describe here. Include the use in the last seven days.

Text...

Outcome Maintaining Health and Wellbeing; Reducing Risk of Harm

Text

RISK ASSESSMENT

Analysis of Need Describe any risk posed by or to the person, whether it is low to high. Is there risk from self, from others or to others. Please describe a detailed explanation and give examples where appropriate. Detail previous history.

Text...

SERVICE USERS VIEWS

Text...

CARER(S) VIEWS

Analysis of Needs How does the carer view the need and issues arising from the assessment? It is particularly important to note where the carer's views are different from the person being assessed. (Please note that the carer who provides regular and substantial care has a statutory right to an assessment of their support needs, which should be recorded in the carer needs section.)

Text...

CARER NEEDS/RESOURCE PLAN

Not Con**o**rded

Analysis of Needs How does the carer view their own needs? Are they able to sustain their caring role? Do they have an independent life from their caring role? Indicate if a carer assessment/resource plan will be carried out to explore these issues further. Note that any person providing regular and substantial care has the statutory right to an assessment of their own support needs.

Text

OTHER(S) VIEWS

Analysis of Needs Others views may include for example next of kin, friends, neighbours, care providers, advocacy services, other professionals.

Text...

Summary of Assessment

Text

Intended Outcomes Suggestion might include: Improvement of quality of life for the carer, better able to manage the caring role, better health and wellbeing outcomes. Examples of outcomes are provided above but the assessing worker should insert person-centred outcomes. Identify the intended outcomes to be achieved for the individuals for this section. Please remember that the outcomes to be achieved should not be a list of service outputs. The outcomes should clearly state what the intended impact or effect will be on the person's life - some of these might be about making a change in the person's life; some outcomes may be

about maintaining his/her current abilities. This may involve services but more importantly people's own networks should be considered.

Text:

SUMMARY OF AREAS IN WHICH INDIVIDUAL HAS ASSESSED NEEDS	
Component Area	Intended Outcomes (Summary of individual outcomes to be achieved for individuals)
Communication Intended Outcome: Improved Communication/Sustaining social contact and company/Valued and Included	
Finance Intended Outcome: Economic Wellbeing	
Personal Care Intended Outcome: Keeping Clean and Comfortable	
Community Living Intended Outcome: Enjoying and Achieving; Making a Positive Contribution; Respected and Responsible	
Home and Domestic Environment Intended Outcome: Enjoying a clean and orderly environment	
Physical Health and Mobility Intended Outcome: Being Healthy/Keeping Active and Alert	
Mental Health Intended Outcome: Improving Wellbeing; Confidence and / or Morale: Regaining skills level capacity	
Drug & Alcohol Dependency Intended Outcome: Maintaining Health and Wellbeing; Reducing Risk of Harm	
Risk Intended Outcome: Staying Safe	
Total IORN (Indicator of Relative Need) Score	

Appendix 16 – Carer’s Review

ORKNEY ISLANDS COUNCIL DEPARTMENT OF COMMUNITY SOCIAL SERVICES & NHS ORKNEY

CARERS OUTCOMES FOCUSED REVIEW FORM

Carer’s Name:		Date of review:			
Current Address:		Tel No:		CHI:	
Post Code:		Mobile No:		PARIS:	
				File:	
Worker Responsible for Review:		Services Used:			
Reason for review:		Date of any previous reviews in last 2 years:			
Changes in circumstances since last assessment / review:					
PERSONS CONTRIBUTING TO THE REVIEW			DATE & METHOD OF CONTRIBUTION		
Name:	Designation / Relationship	Phone	Letter/ report	Individual meeting	Attend review
Any other agencies asked to contribute their view.					
Carer’s Signature:			Date:		
Workers Signature:					
Date:					
SENIOR WORKERS RECOMMENDATION:					
Signed:			Date:		
PERSON RESPONSIBLE FOR NEXT REVIEW:					
Date of Next Review:					
Details input to Database: YES/NO			Date of input:		

QUALITY OF LIFE OUTCOMES:	
What difference does the service(s) make to the carer's life in respect of:	
Their health and wellbeing	Having a life of their own
Supporting or improving the relationship with the cared for person	Accessing financial advice
MANAGING THE CARING ROLE:	
Does the service provide support with the following aspects of caring:	
Informed choices about caring	Being informed/skilled/equipped to care
Satisfaction/sense of achievement in caring	Partnership with the service
PROCESS OUTCOMES:	
To what extent does the carer feel that staff within the service:	
Value and respect them and recognise their expertise as carers	Give them a say in service provision and in shaping services
Respond to their changing needs	Have meaningful relationships with them
Provide accessible and available services	
OVERALL	
To what extent is the service / package of support delivering the outcomes that the carer wants?	
What changes would the carer most like to see?	
What can be changed to deliver these outcomes?	
What must be changed to meet the needs of the carer?	
Is the review of outcomes derived from the carers own reports? If not, what information has been provided and by whom?	

OUTCOMES SUMMARY

Based on the carer's own response where possible, please highlight answers to the following questions:

Are the health and wellbeing of the carer supported by their package of care?
Strongly agree Agree Disagree Strongly disagree

Is the carer supported by their package of care to have a life of their own?
Strongly agree Agree Disagree Strongly disagree

Does the carer feel informed/skilled/equipped to care?
Strongly agree Agree Disagree Strongly disagree

Does the carer feel that they are a key partner in caring?
Strongly agree Agree Disagree Strongly disagree

Does the carer feel satisfied with their involvement in their package of care thinking particularly about whether they have choice, have been supported to make their own decisions and have the information needed to do so?

Strongly agree Agree Disagree Strongly disagree

Does the carer feel supported and capable to continue in their role as carer?

Strongly agree Agree Disagree Strongly disagree

Other information from carer:

DETAILS OF UNMET NEED:

Unmet Need Form Submitted to:

Date:

DETAIL ANY NEW RISK ASSESSMENT:

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